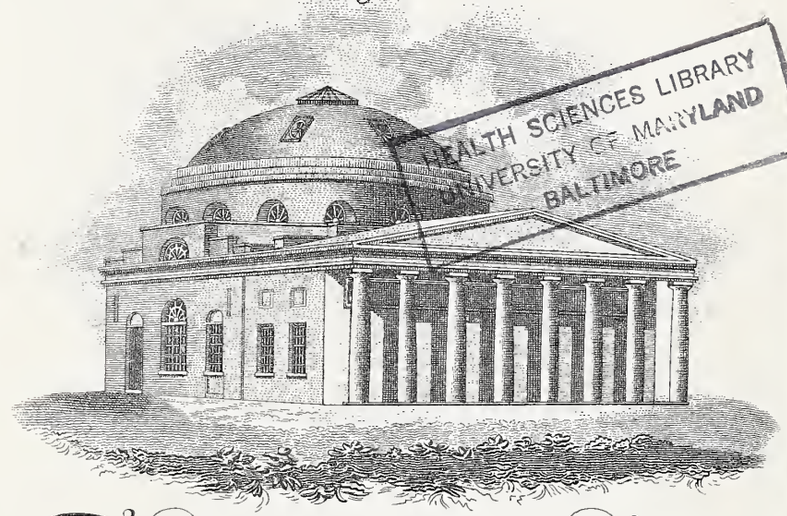
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The Journal

of the

Michigan State Medical Society

Published under the Direction
of The Council

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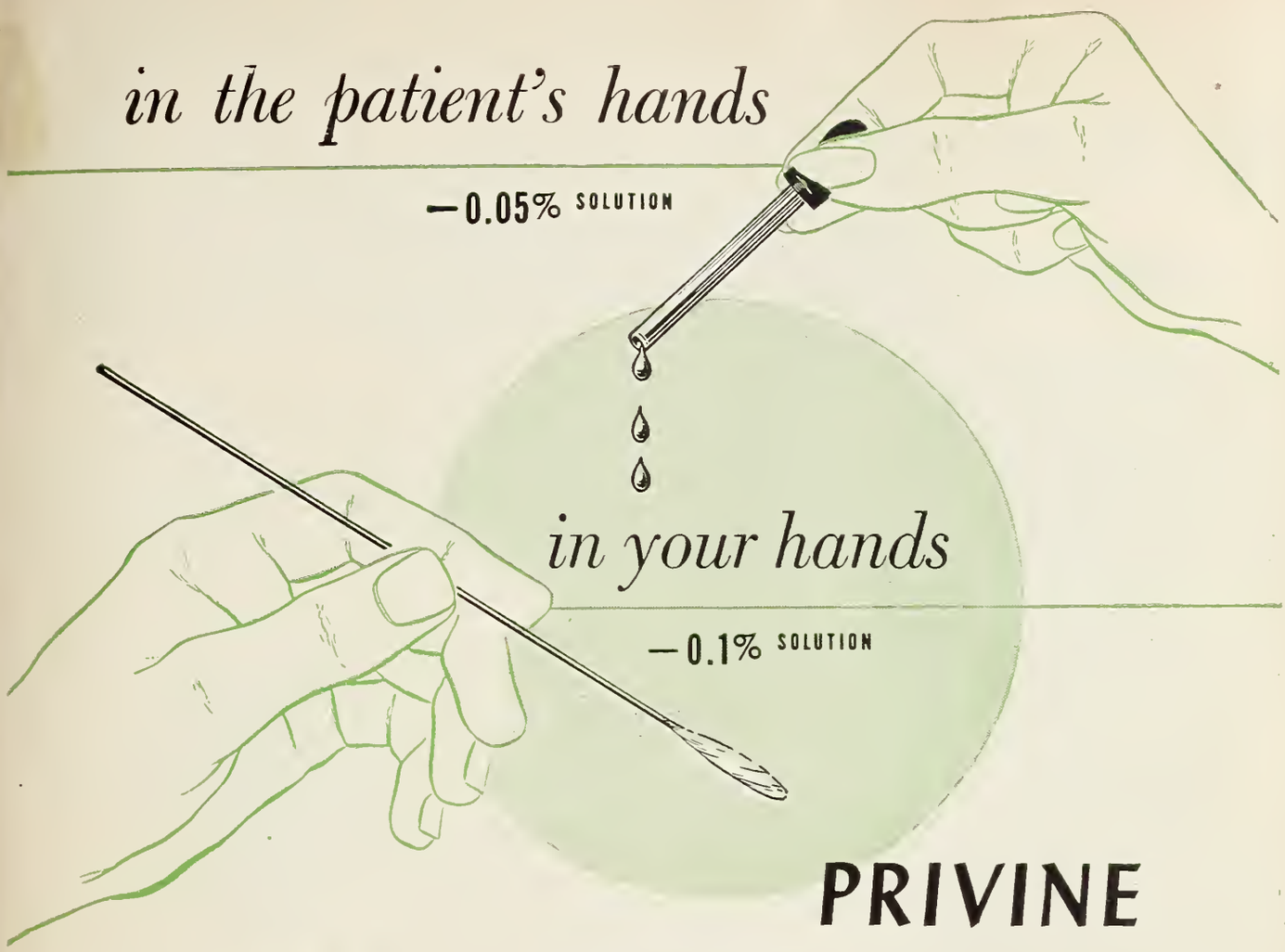


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Political Medicine

"The Veteran's Own Doctor"

Comments by E. F. Sladek, M.D., Traverse City, Michigan, Chairman of the Council, Michigan State Medical Society; Secretary, National Conference on Medical Service

In commenting upon the article "The Veteran's Own Doctor" by William G. Reidy, which appeared in the May, 1947, *Survey Graphic,* I first wish to point out something about which Mr. Reidy has an entirely false conception. The medical profession did not seek this program of veterans medical care. Self-interest was not a factor. The doctors of the country were and are busy with their private practices. Their offices are crowded. Their work is unceasing. Additional tasks, especially those involving the necessary detailed clerical work of a VA program, are not attractive to the doctors.

Here are the facts: Under the old administration, the Veterans Administration program of care of veterans had degenerated almost to the point of public disgrace. When General Omar N. Bradley and General Paul R. Hawley took over, they found all veterans facilities overcrowded, inefficiently and markedly understaffed, and were faced with the separation of 20,000,000 veterans from the armed forces, huge numbers of whom were in need of immediate and continued medical care by reason of their service-connected disabilities. The law requires the Veterans Administration to furnish medical care to these veterans. General Hawley *appealed* to the medical profession for assistance to help him solve this vital problem. This appeal was made on both a patriotic and a humanitarian basis.

Fortunately, a number of states had already existing and functioning medical care organizations which could conceivably be used by the VA to quickly and satisfactorily supply the needed medical care for the veterans of those states. Conferences between the VA and these state organizations led to the conception of the Home Town Care Plans.

The comments by Dr. Sladek pertain to the article "The Veteran's Own Doctor" by William G. Reidy, appearing in the *Survey Graphic* of May, 1947, and submitted for the record of the hearings on S.545 before the Senate Committee on Labor and Public Welfare on June 5, 1947, by Senator Murray. These comments were invited by Senator H. Alexander Smith of New Jersey, chairman of the Subcommittee on Health.

In view of the direct criticism of Michigan Medical Service, and being thoroughly familiar with the situation in Michigan, may I add the following comments.

Seven years ago Michigan Medical Service was established, based entirely upon the ideology of instituting some form of medical service to the population of our state whereby the costs of illness could be reduced and could be met by a system of small monthly payments based on the insurance principle of group coverage.

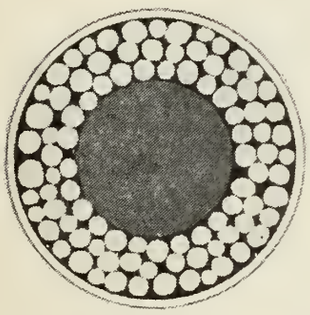
The establishment of Michigan Medical Service was a challenge to the doctors of Michigan. It was their plan and their organization, and they were determined to make it work. Insurance experts were employed, office help employed and trained, IBM machines obtained, and a fee schedule developed and agreed upon. This fee schedule was considerably less than existing private fees throughout the state. The trials and tribulations besetting this new organization, which was dedicated to an entirely new principle of low-cost medical service to the low-income families of our state, were met by a tremendous amount of time devoted to the frequent meetings of the officers and members of the board of directors (66 per cent of whom are doctors of medicine). The services of the officers and councilors of the Michigan State Medical Society were enlisted to contact the component county medical societies and many individual physicians. The monthly secretary's letter and THE JOURNAL of the MSMS were used to contact each individual member of the State Medical Society. All the efforts and the experience of the years resulted in establishing the confidence of the Michigan medical profession in Michigan Medical Service, in the elimination of exploitation, and in the development of the "know how" in administrative methods of payment for medical serv-

(Continued on Page 14)

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LABORATORY TEST

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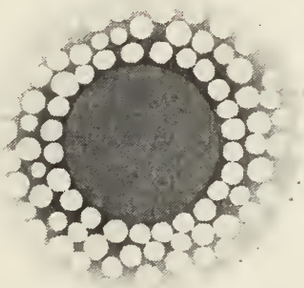


Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.

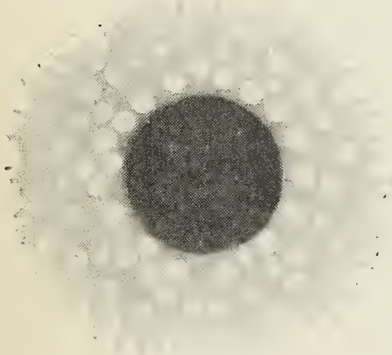


Fig. 3 — Complete disintegration.

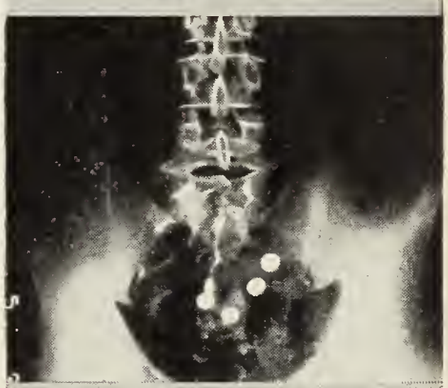
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THE VETERAN'S OWN DOCTOR

(Continued from Page 12)

ices to the population of the state. This organization, Michigan Medical Service, which now supplies 10,000 major medical services per month to its 900,000 subscribers at an administrative cost of only 11.92 per cent of the subscriber's dollar, must have administrative experience.

Surely, this experience of such an established, well staffed, well run, and professionally accepted organization is worth something to a governmental agency seeking its services.

Specifically, Mr. Reidy's article is replete with unproved and unprovable statements. It indicates either lack of investigation to find the facts, or a deliberate misstatement of knowledge for the propaganda purposes of his article. Mr. Reidy states, "All (Michigan) doctors are generally satisfied with what they are getting (under the Michigan fee schedule) except one Detroit physician who had been unhappy since he had seen New Jersey's fee schedule." His intimation is that if all Michigan doctors knew others were getting more for like services they would be unhappy. Ridiculous! The Michigan doctors know all about New Jersey's fee schedule and still are, as Mr. Reidy says, "generally satisfied with what they are getting." In fact, one year before the Veterans Administration contract with Michigan Medical Service was signed, the doctors of Michigan had set up a "uniform fee schedule for wards of governmental agencies, national, state, and county." This fee schedule was developed with the full knowledge and co-operation of all the doctors of the state, including the specialists, and was entirely acceptable to them. The fact that Michigan already had such a "Uniform Fee Schedule for Governmental Agencies" acceptable to its doctors, was a major factor in the institution of the "Home Town Care Plan" in our state.

Mr. Reidy intimates exploitation and abuse in the New Jersey plan—but says it cannot be proved "without a medical review of the cases involved." The meaning of this statement is not clear. Does he mean that each case must again be reviewed by another doctor? Such a procedure would be impossible because of lack of medical manpower. Further, it would result in duplication of effort, requiring two medical examinations with the necessary doubling in cost to the VA. Mr. Reidy intimates that unnecessary treatments are being given in New Jersey because of an increase, over a five months' period, of 50,000 treatments to the same number of veterans. He did not bother to find out the real reason for the increase, which is known to both the Veterans Administration and the doctors: this is not "abuse" but expanded treatments authorized on determination of need by the initial examinations, these examinations having constituted the major portion of the original 31,360 "treatments." Many of these original 31,360 "treatments" consisted of physical examinations to determine the presence of handicaps or disabilities, allegedly service-connected, and the rendering of medical opinion as to probability of the disability being related to a service illness or injury, and whether there is need for treatment. The rendering of necessary treatments based upon the findings of the physical examinations is the real reason for the increase in treatments over the five month period in the New Jersey plan.

Mr. Reidy states, "The Veterans Administration merely delegates a part of the job, pays Michigan Medical Service a 7 per cent fee to get it done and then, in effect, does the same job all over again by itself." Further, he says "Actually the Veterans Administration has not delegated nor has the Michigan Medical Service sought such authority and responsibility" (referring to the "complete responsibility for operating a home-town program"). These statements show a complete lack of knowledge of the Plan. First of all, the Veterans Administration delegates the entire job of furnishing medical care of the veteran to Michigan Medical Service. With this goes the responsibility to provide high quality care that will satisfy Veterans Administration requirements. The Veterans Administration merely determines eligibility and authorizes Michigan Medical Service to furnish the care. This involves the preparation by Michigan Medical Service of reporting forms, simplified, yet containing complete information, to result in minimal clerical work on the part of physicians. It involves the preparation of notices of authorization for medical services, which it sends to the veteran within twenty-four hours of receipt of such authorization from the Veterans Administration. It involves the checking of reports of doctors and the issuing to doctors of authorizations for continued medical care on a monthly basis. Michigan Medical Service is equipped and con-

(Continued on Page 16)

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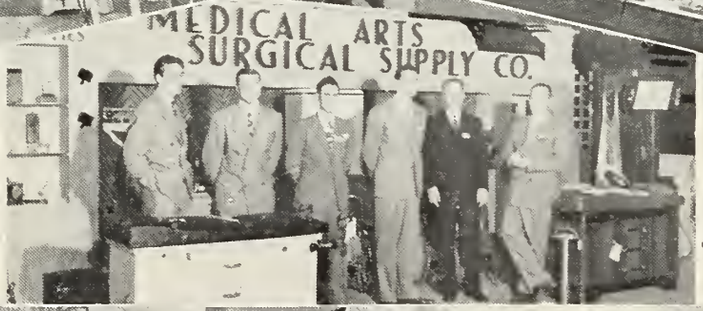
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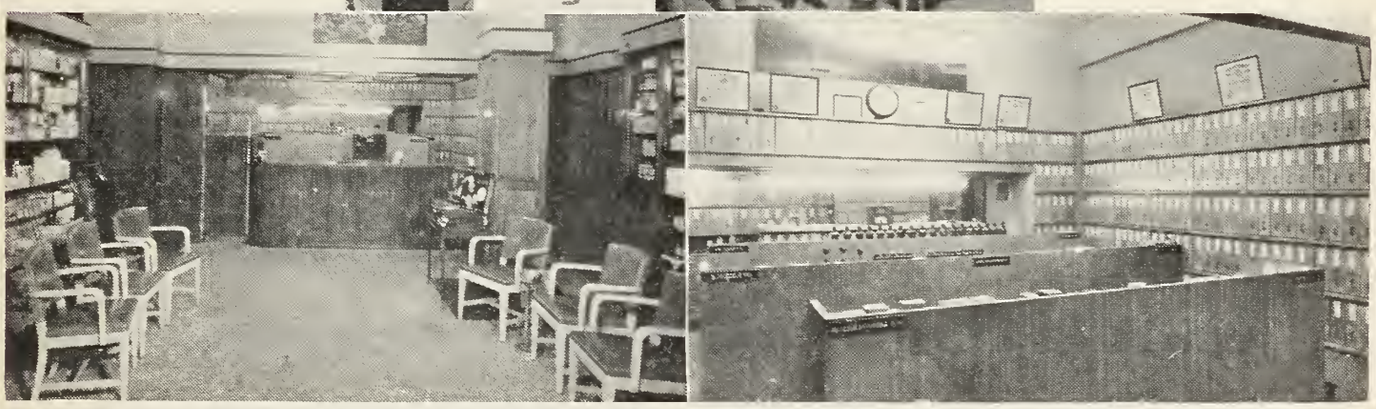






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THE VETERAN'S OWN DOCTOR

(Continued from Page 14)

stantly carries an up-to-date listing of registered doctors of medicine broken down into specialties and communities, and is prepared to furnish veterans with this information. These services alone are of distinct saving to the VA, a saving which cannot be properly estimated but certainly can be shown to be of value equal to or in excess of the administrative fee paid to Michigan Medical Service.

In addition, upon receipt of the completed report from the doctor, Michigan Medical Service reviews it, and checks to see if the service rendered was in keeping with the authorization. When incomplete or inadequate reports are received they are returned to the doctor with suggestions concerning what is required. Michigan Medical Service has a staff of field representatives who continually visit doctors' offices to check on the cases at hand, giving advice relative to the proper completion of reports when needed. If the report is in order, payment is made to the doctor by Michigan Medical Service. Vouchers listing 100 cases are then sent by Michigan Medical Service to Veterans Administration. This vouchering system alone saves a lot of time and effort on the part of the Veterans Administration because the vouchers are uniform and payment is made to one organization rather than to thousands of individual physicians,

The Veterans Administration does not perform these duties all over again. If the Veterans Administration attempted these operations, they would need an additional staff in Michigan comparable to that employed by Michigan Medical Service, and it is very likely that this staff would have to be much larger to get the same results that have been gained through the services of Michigan Medical Service.

When I buy an automobile I select the make of car, first, because I believe it to be a good car, and secondly, because I have confidence that that particular manufacturer has an organization which will see to it that my car will give me satisfactory service. The original payment does not complete the contract.

When the Veterans Administration contracted for Home Town Care of service-connected disabilities of their Michigan veterans, they not only were assured that payment for these services would be prompt, but they also bought a number of other factors:

1. They were assured of the prompt state-wide operation of the plan through an existing and functioning organization.

2. They were assured of the services of a well staffed experienced organization, fully equipped to handle the details of contact between the individual physicians of the state and the Veterans Administration, thus eliminating obnoxious red-tape.

3. They were assured of the confidence of the doctors of the state in the program. The Michigan State Medical Society, at its own expense, prepared a brochure which was sent to every doctor and to every Service Officer of the veterans organizations of the state, fully explaining the entire plan for veterans care. This was at no cost to the Veterans Administration or the Government.

4. They were assured that their sick veterans would get prompt medical care by reason of quick mailing of authorizations for medical service following certification of a service-connected disability.

5. They were assured of excellent medical care for their veterans in that professional competition still exists under this program, and it is the distinct privilege of the veteran to select the best available medical care existing in his community, and also that the use and payment of consultants and specialists is a definite factor in the Michigan Medical Service plans.

6. They are assured of a minimal amount of exploitation by reason of its elimination by Michigan Medical Service in its general medical care program. *Experience speaks.* As an example, may I quote a paragraph from my original presentation: "A classic example of how the voluntary prepaid medical care plan can be adopted to care for the medically indigent is supplied by the home town plan for the care of veterans now being carried on in Michigan under Michigan Medical Service. The type of co-operation which may be expected from doctors under such a plan is evidenced by the fact that while no veteran has been given less than adequate and proper care, nevertheless only 60 per cent of the authorizations for care granted by the Veterans Administration have been used by our Michigan doctors of medicine. Example: a veteran is allowed ten treatments for

(Continued on Page 18)

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Medical Public Relations—1948 Model

The 1948 model automobiles will look better, drive better and ride better because of new design and advanced engineering. In like manner, the 1948 public relations program of the Michigan State Medical Society will increase in power and performance. There are few drastic and revolutionary changes in the cars and few in the public relations program. The improvement is based on sound experience from the 1947 and preceding models and the new models will be more efficient and more streamlined because of new knowledge intelligently applied.

A larger Public Relations Committee has been appointed—some thirty-six members and in a meeting held on November 23 in Lansing it developed a program with the following features: (1) A ten-minute moving picture prepared by the Jam Handy Associates for release through Michigan's commercial theaters, to be followed by three more pictures if the first lives up to expectations; (2) continuation of the highly successful "Tell Me, Doctor" radio series, now broadcast over seventeen stations daily, with the addition of new stations to the transcribed network to cover the few remaining spots where the program is weekly heard; (3) the University of Michigan—MSMS scientific radio program leaves radio station WJR, Detroit, to be heard over a series of small stations located throughout the state with sixteen programs to be presented by doctors outside of Ann Arbor; (4) the effective Health News Column continues as does newspaper advertising with the variation that any county medical society has the prerogative of refusing newspaper advertising originating in its area; (5) additional organizational effort is planned for a second Rural Health Conference and also for the reactivation of the Michigan Health Council with the addition of Community Health Councils; (6) a down-to-earth movement will be aided by the publication of the "Medical Plan for Michigan," a compendium of the many activities which contribute to the people's health and welfare being carried on by organized medicine in Michigan; (7) schools come in for increased attention with the publishing of the brochure on "Medical Associates." This publication prepared by the MSMS Commission on Health Care develops the vocational fields of those who aid doctors of medicine in serving the health needs of the people; (8) a portion of the fund accruing from the public education assessment was set aside for a "rainy day" with the amount of moisture to be determined by The Council; (9) window displays are made available to county medical societies and the entire program is rounded out with some smaller items of a preparatory nature of which you'll hear more later.

Part and parcel of good public relations is understood to be constructive effort by doctors of medicine as a group as well as individually, to (A) better serve the interests of the public, and (B) cease activities that are detrimental and/or disturbing to the public. But every package has a wrapper, and as a savvy politician has said: "Folks like to know what you're doing. If you do all right **and they hear about it,** you'll get the votes." That applies to medicine's organizational activities just as it does to politics—at least the Public Relations Committee thinks so.

THE VETERAN'S OWN DOCTOR

(Continued from Page 16)

his particular illness; the doctor, who would have been paid for ten treatments, finds the patient needs but six treatments to effect a cure; the government has been spared the cost of the additional four treatments. This record indicates that the doctors, far from being greedy, as is occasionally charged, have given the veteran the best care they knew, with results beneficial both to the patient and the government. This is the kind of co-operation that can be expected from a voluntary medical care program in which the medical profession has confidence."

To one who knows the facts, Mr. Reidy's article cannot be considered as good evidence on which to base a possible governmental activity. However, it is good evidence for only one thing: evidence of the deliberate use of half-truths and misrepresentation by certain individuals in their efforts to delude the people in respect to the activities which are being carried on by a public-spirited profession in the people's interest. It is obviously a part of a propaganda program to foist upon the people a system of compulsion foreign to the American way of life.

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"no tummy upsets for me, doctor"



Health Service Award to Don E. Johnson

Don E. Johnson of Flint, patron of education in cancer control, was presented with the Health Service Award of the Michigan State Medical Society in Flint on December 9. The occasion was the annual meeting of the Genesee County Medical Society at which the retiring officers, headed by President W. Z. Rundles, M.D., Flint, handed the reins of administration to the incoming officers. Frank D. Johnson, M.D., the new president, Harold H. Hiscock, M.D., president-elect, and E. P. Griffin, M.D., Flint, secretary, were formally introduced to the membership.

Among the honored guests were P. L. Ledwidge, M.D., Detroit, MSMS president; E. F. Sladek, M.D., Traverse City, MSMS president-elect; L. Fernald Foster, M.D., Bay City, MSMS secretary; R. C. Pochert, M.D., Owosso, councilor of the Sixth District; Carleton Dean, M.D., Lansing, director Michigan Crippled Children Commission; C. L. Weston, M.D., Owosso, member MSMS Public Relations Committee, and Wm. J. Burns, Lansing, MSMS executive secretary. One hundred and fifteen were present at the dinner meeting.

President Ledwidge, in making the Health Service Award to Mr. Johnson, stated:

"There are in most communities comparatively few people who are truly civic-minded—civic-minded to the extent that they are willing to make personal sacrifice for the common good. Still fewer in this group of civic-minded individuals are those who have a broad and sympathetic understanding of medicine and its problems as they relate to the welfare of the public. To these rare individuals organized medicine owes a debt of gratitude. Acknowledging this debt, the Council of the Michigan State Medical Society voted several months ago to make a Health Service Award to those who can qualify. Such a man is Don Johnson. This award, of no material value in itself, is pregnant with the deep appreciation of our five thousand members. The personal qualifications to merit one of these awards are high, and the evidence supporting these qualifications must be authentic. As it has not been our good fortune to know Mr. Johnson before tonight, we felt it best to take depositions from those who really know him. So through our superdective, pseudo-legal advisor and good friend, Dr. Ray S. Morrish, a deposition has been obtained from one who not only knows Mr. Johnson well but who, as an employe, is an eye-witness to his everyday living.

"Don Johnson is now president of the Michigan Branch of the American Cancer Society. He has underwritten all Cancer Day activities for the Genesee County Medical Society. It was activities of this type that we had in mind when we said 'civic-minded to the extent that they are willing to make personal sacrifice for the common good.'



Presentation of MSMS Health Service Award to Donald E. Johnson, Flint, December 9, 1947.

Left to right, Mr. Johnson; F. D. Johnson, M.D., Flint, president Genesee County Medical Society; P. L. Ledwidge, M.D., Detroit, president Michigan State Medical Society, who made the presentation.

"The people of Flint are fortunate indeed to have in their midst a man with such basic loyalty to his home town; a man blessed with this world's goods and with the disposition to share these blessings with others; a man who so obviously believes in the old saying, 'You can't have a friend without being one.'

"Mr. Johnson, it is a privilege and a pleasure to present to you on behalf of the members of the Michigan State Medical Society this scroll as a token of our appreciation and esteem, and with it goes our sincere wish that you may live long as the master of your estate, 'Henpeck,' to serve the people of the community you love."

* * *

The Genesee County Medical Society announces its Third Annual Cancer Day to be held Wednesday, March 31, 1948, at Flint.

Five outstanding speakers from the fields of general surgery, radiology and the surgical specialties will present the scientific program between 9:00 A.M. and 5:00 P.M. in Merliss Brown Auditorium, Hurley Hospital, Flint.

All members of the Michigan State Medical Society are cordially invited to attend.

For detailed program, write Geo. J. Curry, M.D., Chairman Program Committee, 348 S. Saginaw, Flint.

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You and Your Business

RESOLUTION RE CANCER DETECTION CENTERS

Adopted by House of Delegates of Michigan State Medical Society, September 22, 1947.

"WHEREAS, great publicity programs and widespread organization of lay agencies on a national scale have stimulated an unprecedented public interest in and demand for the detection and control of cancer, and

"WHEREAS, such public interest and demand are being implemented by means of cancer detection clinics, by legislative aids for the investigation and study of cancer, and by public and private grants of funds for various activities in relation thereto, and

"WHEREAS, many of such well-intentioned projects may become misdirected, dissipated or otherwise diverted from their primary purposes unless they are given competent professional medical leadership and direction, and

"WHEREAS, the public has at all times had reliance on doctors of medicine for the detection and control of cancer; now, therefore, be it

"RESOLVED: That the Michigan State Medical Society does reaffirm its purpose to stimulate, encourage and assist all proper measures for the detection, study, treatment and control of cancer; and be it further

"RESOLVED: That each county or district medical society of Michigan, either by itself or in conjunction with the surrounding county groups, is urged to create facilities for the appropriate handling of the cancer problem, and that it be responsible for cancer activities in its own area; and be it further

"RESOLVED: That these facilities be used for the detection of cancer among those who are not able to employ the services of a doctor of medicine; and be it further

"RESOLVED: That any expansion or alteration of such a program be undertaken only by the approval of the county medical society."

* * *

ACTION RE RH FACTOR DETERMINATION

Adopted by House of Delegates of Michigan State Medical Society, September 22, 1947.

"That recommendation be made to State Department of Health that these tests be performed in areas where they are not available on a private basis and to those who cannot afford to have them done in a private laboratory."

* * *

NOT A FAIR SAMPLING

Advocates of compulsory health insurance assume that the statistical sample examined by draft boards was representative of the country's young adult male population. That is not quite true. In the first two years of the war, the draft boards examined about 10 million men and rejected 36 per cent of them. But during that same period, over 2½ million men enlisted voluntarily. If these men had gone through Selective Service, the over-all rejection rate would have dropped automatically from 36 to 28 per cent.

Then there's another group that draft rejection figures do not cover. Of the manpower that remained after voluntary enlistments, more than one-third received deferments because of essential occupation or dependency. In other words, Selective Service examinations were limited to those young adult males who did not volunteer and who did not rate deferments because of their value to war industry or to their families. That's scarcely a true cross-section It is apparent that only about 19 per cent of draft rejections could have been influenced by medical care. And to obtain this figure, we must assume: (1) That every person with a correctable abnormality would have sought medical attention; (2) That the physician would have recommended corrective measures including major surgery where necessary, in each case; (3) That the patient would have consented; (4) That the recommended procedures would have been 100 per cent effective every time. Such assumptions do not fit in with our everyday experience. —MAURICE H. FRIEDMAN, Ph.D., M.D., before the Health Subcommittee of the Senate Committee on Labor and Public Health.

* * *

BRITISH MEDICAL PUBLICATIONS

All periodical publications of the British Medical Association are now obtainable through Grune & Stratton, Medical Publishers, 381 Fourth Avenue, New York 16, New York, who have been appointed by the Association sole agents for the United States beginning with January, 1948.

The journals are: *British Medical Journal,* published weekly, $14 a year; *Abstracts of World Medicine,* published monthly, $13 a year; *Abstracts of World Surgery, Obstetrics and Gynecology,* published monthly, $9 a year.

Quarterly journals, uniform subscription rate $5.50 a year, are: *Annals of the Rheumatic Diseases, Archives of Disease in Childhood, British Heart Journal, British Journal of Industrial Medicine, British Journal of Pharmacology and Chemotherapy, British Journal of Social Medicine, British Journal of Venereal Diseases, Journal of Clinical Pathology, Journal of Neurology, Neurosurgery and Psychiatry, and Thorax.*

* * *

MHS LIBERALIZES POLICY

Liberalization of benefits for its subscribers receiving service in hospitals not participating in the Blue Cross program have been announced by William S. McNary, Executive Vice President of Michigan Hospital Service, the Blue Cross Plan.

This liberalization in benefits has been made available without an increase in subscriber rates, McNary said.

(Continued on Page 24)

SPECIAL FOR JANUARY, 1948

Aminophylline

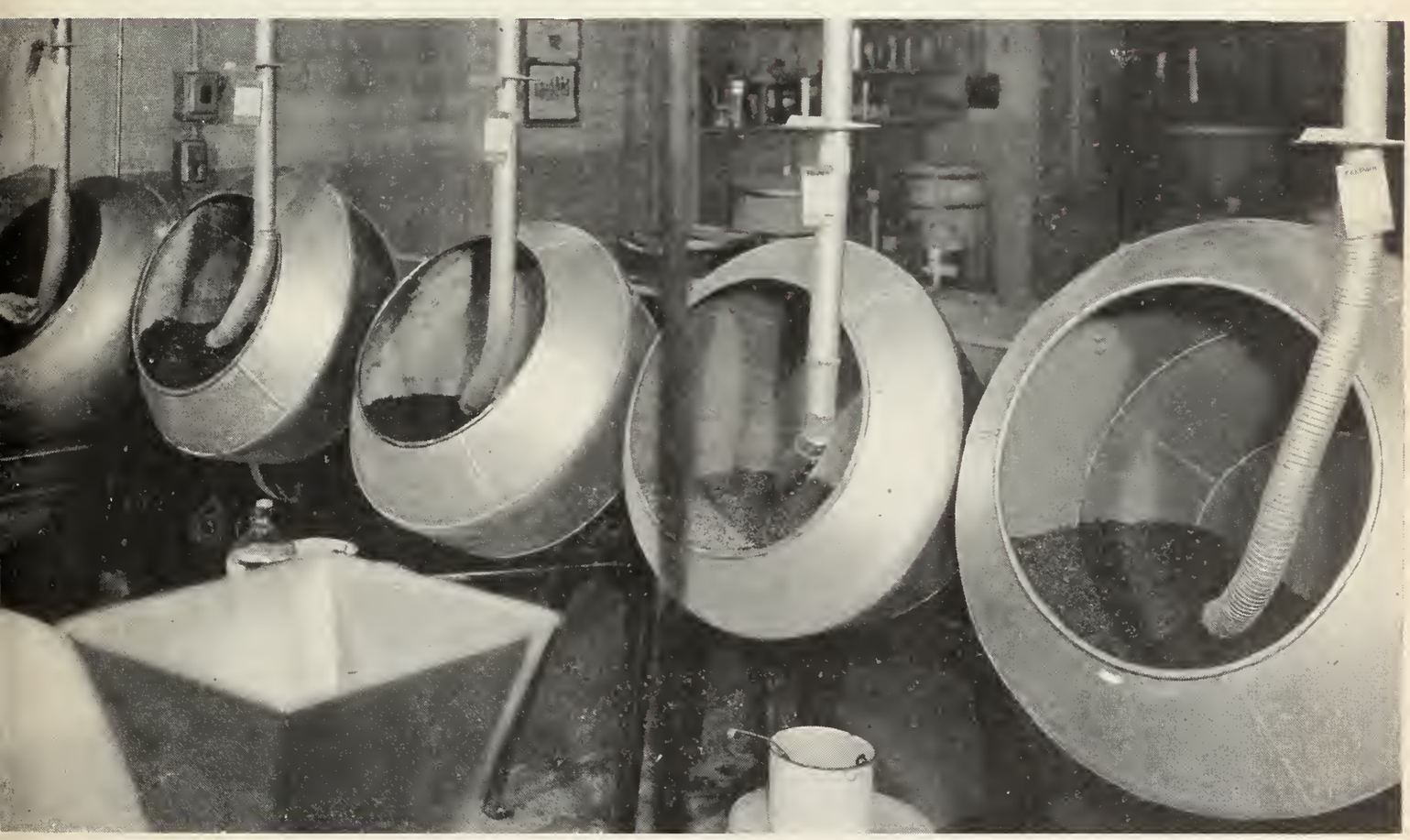
Each tablet contains. Aminophylline (Theophylline with Ethylene Diamine) 1½ gr.

1,000	$ 5.00
5,000	22.00
10,000	40.00

Regular Price....$6.00 per 1,000
Sales Tax and Postage Extra

7 Floors of Pharmaceutical, Surgical, Medical Supplies

Below: Battery of Tablet Coating Machines



TRADE MARK

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MHS LIBERALIZES POLICY

(Continued from Page 22)

Entitled to complete hospital service in a Blue Cross member hospital, Blue Cross subscribers are protected under an emergency clause in the Blue Cross Hospital Care Certificate when "in case of emergency" they are "admitted to a non-participating hospital."

The emergency benefits (benefits provided when admitted to a non-participating hospital) will provide for Blue Cross group subscribers protected under a Semi-Private Contract: Up to $6.50 per day for a period not to exceed 30 days for any one disability, and up to $3.25 a day for an additional 90 days toward the hospital's regular charges for semi-private room service, meals and general nursing service.

In addition, effective December 1, 1947, and until further notice, they will receive an allowance, per hospital stay, up to $32.50 toward the hospital's charges for those other services listed as benefits in the certificate such as operating room, anesthesia, laboratory examinations, oxygen therapy, and drugs and dressings, et cetera.

Blue Cross group subscribers enrolled under a Ward Contract will be entitled to the following in a non-participating hospital: Up to $5.00 per day for a period not to exceed 30 days for any one disability and up to $2.50 a day for an additional 90 days toward the hospital's regular charges for ward room service, meals and general nursing care.

An allowance is made per hospital stay up to $25.00 toward the hospital's charges for those other services listed as benefits in the certificate such as operating room, anesthesia, laboratory examinations, oxygen therapy, and drugs and dressings, et cetera.

Posters and notices announcing the contract liberalization have been sent to all county medical societies.

* * *

NOT ONE MOTHER LOST AT MUNSON IN EIGHT YEARS

James Decker Munson hospital in Traverse City is the possessor of a remarkable maternity mortality record—not a single maternal death has been recorded at the hospital during 3,582 deliveries at the institution since 1940.

This fact was disclosed October 17, 1947, as the result of a survey of hospital records covering an eight-year span, and officials pointed out that while the check went back only to include 1940, the excellent record may extend well beyond that point.

It was impossible to check deaths of newborn babies during the period covered by the survey.

The survey also revealed a steady increase in the number of births at the hospital each year since 1940. A breakdown shows the following deliveries by year: 1940—301; 1941—360; 1942—398; 1943—369; 1944—374; 1945—463; 1946—614. Through November 10, 703 births had been recorded at the hospital for this year, making a total of 3,582.

A comparison of Munson's perfect record with Michigan's maternal death rate is interesting. As of the last report the maternal death rate for the state is 1.96 per thousand. On this basis, the hospital should have lost seven mothers.

Officials pointed out that Michigan's maternal mortality rate has dropped from over seven per thousand in 1919 to its present figure of 1.96, which, incidentally, is much lower than for the United States at large.

They also emphasized that the local hospital's record was established despite the fact that all the desired facilities for maternity care are not available and that this department of the hospital has been crowded throughout the survey period.—*Record Eagle,* Traverse City, October 15, 1947.

* * *

VENEREAL DISEASE CONFERENCE, MARCH 13

Doctor, you are cordially invited to attend the one-day conference on "Modern Diagnosis and Treatment of Venereal Diseases" at the Detroit Intensive Treatment Center, Herman Kiefer Hospital, Detroit, on Saturday, March 13, 1948.

Sponsors: Michigan State Medical Society, Department of Postgraduate Medical Education, University of Michigan, and Wayne University College of Medicine.

Presiding: L. W. Shaffer, M.D., Detroit, Chairman, MSMS Committee on Venereal Disease Control

Differential Diagnosis of Venereal Diseases. Case Demonstrations.

9:00- 9:50 a.m.	"Chanchroid" "Lymphotopathia Venereum" "Granuloma Inguinale" *L. W. Shaffer, M.D.,* Detroit, Professor of Dermatology and Syphilology, Wayne University College of Medicine.
9:50-10:40 a.m.	"Gonorrhea"—*George Sewell, M.D.,* Detroit, Associate Professor of Urology, Wayne University College of Medicine
10:40-10:55 a.m.	Intermission
10:55-11:45 a.m.	"Syphilis"—*Udo J. Wile, M.D.,* Ann Arbor, Professor Emeritus of Dermatology and Syphilology, University of Michigan School of Medicine
11:45-12:30 p.m.	Discussion
12:30- 1:30 p.m.	*Subscription Luncheon,* Herman Kiefer Hospital Cafeteria
1:30- 2:00 p.m.	"Treatment of Early Syphilis"—*H. L. Keim, M.D.,* Detroit, Associate Professor of Dermatology and Syphilology, Wayne University College of Medicine.
2:00- 2:30 p.m.	"Treatment of Syphilis and Pregnancy"—*Steven F. Horne, M.D.,* Ann Arbor, Instructor in Dermatology and Syphilology, University of Michigan School of Medicine
2:30- 2:45 p.m.	Intermission
2:45- 3:15 p.m.	"Treatment of Central Nervous System Syphilis"—*Arthur C. Curtis, M.D.,* Ann Arbor, Professor of Dermatology and Syphilology, University of Michigan School of Medicine
3:15- 3:45 p.m.	"Interpretation of Serological Tests"—*G. D. Cummings, M.D.,* Lansing, Director of Laboratories, Michigan Department of Health
3:45- 4:15 p.m.	"Syphilis and Marriage"—*John A. Cowan, M.D.,* Lansing, Director, Bureau of Venereal Disease Control, Michigan Department of Health
4:15- 4:30 p.m.	Discussion Adjournment 4:30 p.m.

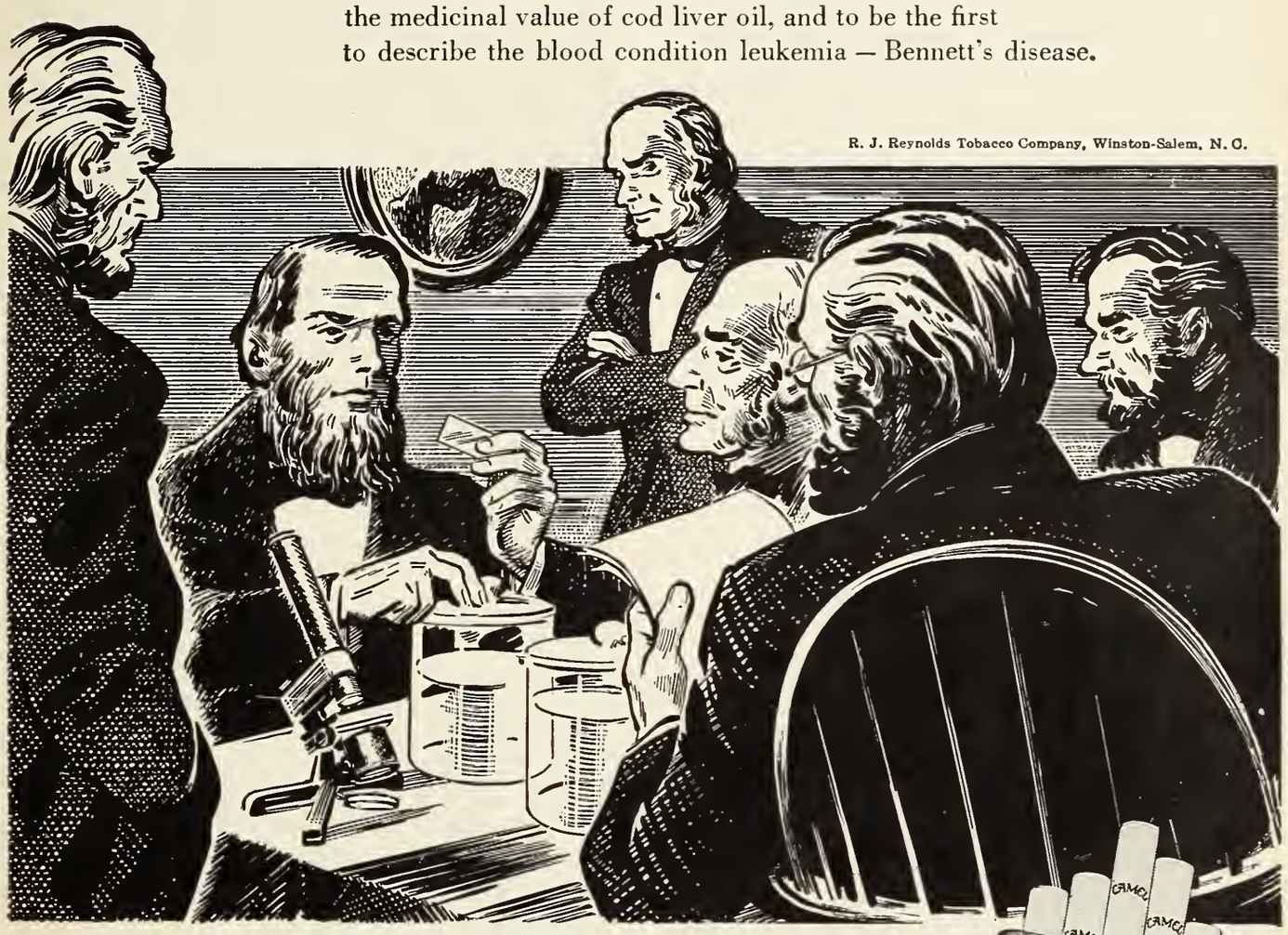
(Continued on Page 26)

Experience is the Best Teacher

JOHN HUGHES BENNETT (1812-1875) proved it in histology

Bennett's experiences, gained by linking physiology with clinical medicine, led him to institute the practical study of histology, to recognize the medicinal value of cod liver oil, and to be the first to describe the blood condition leukemia — Bennett's disease.

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.



Yes! And experience is the best teacher in smoking, too!



DURING the wartime cigarette shortage, people smoked many different brands—any brand they could get. And as they smoked—they naturally compared the different brands . . . for taste, for mildness, for coolness . . . for all-round smoking enjoyment. More and more smokers found from the experience of those comparisons that Camels suit them best.

Result? *More people are smoking Camels than ever before!*



According to a Nationwide survey:

More Doctors Smoke CAMELS

than any other cigarette

Three nationally known independent research organizations asked 113,597 doctors — in every branch of medicine — to name the cigarette they smoked. *More doctors named Camel than any other brand.*

(Continued from Page 24)

NOT PAYABLE AFTER SIXTY DAYS

Doctor, have you sent in your bills for this month to the Michigan Crippled Children Commission for the medical care of afflicted and crippled children? The Commission's address is 458 Hollister Bldg., Lansing, Michigan.

Doctor and hospital bills are not payable after 60 days from date of service rendered. Send your bills monthly to the MCCC. The hospital no longer is charged with the responsibility of sending the doctor's bill to the Commission. This is now the physician's privilege by statute.

* * *

BILLING UNDER THE UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

The Michigan Veterans' Trust Fund Board of Trustees feels that Michigan doctors are contributing a great deal to World War II veterans and their dependents by co-operating with the hospitalization program of the Michigan Veterans' Trust Fund, according to Mr. L. J. LaLone, Executive Secretary.

Mr. LaLone points out that in most instances the minimum fee schedule for government agencies is being followed without deviation by the vast majority of Michigan doctors. In a few instances, however, doctors are still under the impression that two fees may be charged for a specific major operation. However, according to the fee schedule only one fee is indicated. Thus, the fee schedule designates the fee and when the doctor presents his statement he should bill according to the item number and amount specified under that number for medical or surgical service. Strict adherence to instructions in the uniform fee schedule will facilitate payment under the provisions of the Michigan Veterans' Trust Fund program.

* * *

VETERANS CARE PROGRAM—MMS

A recent letter from Michigan Medical Service to all doctors participating in the Veterans Care Program invited attention to the fact that many VA forms for authorized treatment had not been returned to Michigan Medical Service. Consequently funds which had been allocated for these outstanding authorizations have been frozen.

To rectify this situation, the letter pointed out, the VA had requested MMS to cancel all authorizations for services which had been outstanding for a period of thirty days or longer and doctors were urged to comb their files for any such unreported forms.

Michigan Medical Service, in reviewing the authorization procedure, discovered that the cause of the backlog was the veteran himself. Many times the veteran did not report to the physician for treatment and as often started but did not complete the series of treatments within the specified period for which the authorization was issued. In rare instances the doctor had misfiled or had forgotten to return the form.

It is the aim of Michigan Medical Service to keep the administrative procedure of the Veterans Care Program as simple as possible, eliminating all unnecessary forms and reports. The doctors themselves can aid in this function and materially speed up payment for service rendered if they will follow through on these few points concerning authorizations for treatments:

1. Return all authorizations for service immediately following the expiration date. (All authorizations are issued for a period of thirty days only—service cannot be rendered after the expiration date of the authorization.)

2. If the veteran has not reported for treatment within the period shown, return the form indicating that the veteran did not report.

3. If the veteran started but did not return to complete the treatments authorized within the time limits shown, indicate amount of service rendered and return form.

4. Check your files for any outstanding forms that have been voided by time and return to Michigan Medical Service.

* * *

RATS—AND FOOD

Huge quantities of food are lost every year as a result of the depredations of rats. The rat population in rural districts is several times that of the human population. Rats not only spread typhus and other diseases by means of the fleas with which they are infested, but also eat or destroy the very food now most greatly needed—grain. A nationwide rat elimination campaign would be very profitable. New rat poisons are now available which are far more efficient than any others used heretofore. Here is a worth while project for every community. Boy Scouts could be enlisted in this work. Farmers should be urged to wage unrelenting warfare against rats and instructed in the best methods of getting rid of these pests. They swarm around granaries and usually spoil more grain than they eat. Rats kill thousands of chicks each year and these loathsome creatures frequently raid hen houses and carry away eggs. In towns and cities rats sometimes cause fires by removing insulation from electrical wiring, thus causing short circuits. During this critical period we cannot afford to feed an army of five or six hundred million rats, perhaps even more. Here is a food conservation program that will show immediate results.—*Good Health,* November, 1947.

MSMS

"To be good is noble, but to teach others to be good is nobler and less trouble."

—Mark Twain

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Surgical Treatment of Carcinoma of the Breast

By Stuart W. Harrington, M.D.
Division of Surgery, Mayo Clinic
Rochester, Minnesota



I AM PLEASED to have the opportunity to present the subject of carcinoma of the breast because it constitutes such a vital part of the general cancer problem.

The mammary gland is one of the most common sites of malignant disease of women, among whom breast cancer is second in occurrence only to malignant disease of the uterus. The outstanding features of general statistical studies of malignant disease of the mammary gland are the alarming increase in the frequency of its occurrence, as well as the increased mortality rate from the disease. In the United States registration area, the mortality rate per 100,000 population was 5 in 1901. This increased to 11.6 per 100,000 in 1944, during which year 16,379 patients died from carcinoma of the breast, the greatest annual number of deaths from the disease ever recorded. The serious significance of these facts, as well as the fact that many patients delay seeking medical advice in regard to conditions of the breast, has led to an intensive educational program in which patients have been warned not to disregard any abnormalities of the breast. In this program members of the medical profession have participated for many years.

The results of treatment of malignant disease of the breast were markedly improved following the introduction of radical surgical operation. This method of treatment has been that most generally accepted by the medical profession because, if the condition is confined to the breast at the time of operation, complete eradication of the disease can be expected. One of the principal reasons for failure of surgical operation to accomplish this objective uniformly is the high percentage of cases in which metastasis has occurred by the time the patient comes to operation. I believe that the greatest possibility of improving the results, if present methods of treatment continue to be utilized, lies in intensification of the educational program. Although this educational program has seemed slow in accomplishing its objective, it now appears that, compared with former years, a greater percentage of patients are seeking advice for lesions of the breast and are being treated earlier in the course of the disease. This new tendency, I believe, will result in the greatest advance in the treatment of these malignant lesions since the epoch-making contribution of radical amputation by Halsted. My hopeful attitude is based on a study of 7,138 cases of unilateral carcinoma of the breast in women encountered at the Mayo Clinic in the thirty-four year period, 1910 to 1943, inclusive. In 1943, 47.0 per cent of the patients had axillary metastasis at the time of operation. In only one previous year, 1940 (48.8 per cent), has this percentage been less than 50. Even though the apparent present trend is encouraging, the aim must be to institute treatment in all cases, before metastasis has occurred.

The most important consideration in the treatment of carcinoma of the breast is its early recog-

Read at the eighty-second annual session of the Michigan State Medical Society, September 25, 1947, at Grand Rapids, Michigan.

nition. There are no pathognomonic signs or symptoms by which all malignant growths can be recognized. This, unfortunately, is particularly true of early lesions and emphasizes the importance of considering every lesion of the breast as possibly malignant. The clinical signs and symptoms depend on the duration of the lesion at the time of examination; accurate diagnostic signs and symptoms are hopelessly inadequate in determining early malignant disease. If sufficient time is permitted to elapse, it is probable that 100 per cent of these conditions could be diagnosed clinically but meanwhile much valuable time will be lost before treatment is instituted and, in most instances, the patient will have lost any possibility of obtaining permanent cure from surgical treatment.

Pain or the absence of pain is often of diagnostic importance. Pain may be the only subjective symptom, as well as the initial symptom of malignant lesions of the breast but, unfortunately, pain is present in only approximately 8 to 10 per cent of the cases. The pain is usually of a sharp, lancinating, transitory type, which the patient often describes as a "twinge" causing her to place her hand on her breast and find a tumor. The great majority of malignant lesions are not painful, which is one of the chief reasons why patients in all walks of life who have malignant disease delay examination even after they have discovered a tumor. In many instances they do not come for treatment until the lesions have become ulcerated and extensive nodal metastasis has occurred.

The physical characteristic of attachment of the skin to underlying lesions of the breast is one of the most important and characteristic clinical signs of malignant lesions. The skin is usually more or less fixed to underlying malignant growths, but this is not pathognomonic, for a moderate degree of attachment may be present in some cases in which the lesion is benign. Attachment of the skin to the underlying lesion was noted in about 75 to 80 per cent of malignant lesions. However, I should like to emphasize that this is not an early sign of malignant disease. In studying these with reference to the presence or absence of involvement of lymphatic structures, it was found that in 72.6 per cent of these patients metastasis to the regional lymph nodes had occurred. This indicates that if malignant lesions are to be treated early, the diagnosis must be made before attachment of the overlying skin is demonstrable. The only safe method by which to accomplish this is to remove the tumor for microscopic study immediately on its discovery.

From a surgical standpoint, the cases of lesions of the breast which require most careful consideration are those in which a definite diagnosis cannot be made clinically, and in which the question arises whether it is best to keep the patient under observation or to treat the condition surgically. In all cases in which there is a single, localized tumor, without definite clinical signs of malignant disease, the only safe way to establish a definite diagnosis is by surgical removal of the tumor for microscopic examination. The tumor should be removed by wide excision, well away from the limits of the growth, and without trauma to the lesion. Usually I prefer to remove an elliptical or wedge-shaped portion of mammary tissue, including the tumor. Microscopic examination of the tumor should be made immediately after its removal, before the incision is closed. If the tumor proves to be malignant, the operation should be completed as a radical amputation.

I do not believe that it is ever justifiable to remove any growth from the breast without immediate microscopic examination of frozen sections of the tissue. The manner in which the operation should be completed is indicated by examination of the tissue; the poorest surgical results in carcinoma of the breast are obtained from secondary radical amputation after primary partial removal of the tumor or the breast. In approximately 10 per cent of the cases in which radical mastectomy has been performed at the Mayo Clinic, a minor operative procedure had been performed elsewhere one month or more prior to the patient's coming to the clinic. In this group, involvement of lymphatic structures has occurred in 74 per cent of cases, as compared with 59.3 per cent of cases in which primary radical operation had been performed. The results of secondary radical amputation are correspondingly less satisfactory than those of primary radical amputation. These cases, in which a secondary radical operation was performed after primary minor operation, do not give a correct impression of the results obtained in the entire group of cases in which primary minor operative procedures had been done for malignant disease, as it was found that in more than 60 per cent of such cases the condition was hopelessly inoperable at the time the patients presented themselves at the clinic. This is particularly true when

some type of escharotic paste has been used on the breast primarily, for, in more than 80 per cent of these cases, the condition is inoperable.

Radical Amputation

From the standpoint of operative procedure, the best results from surgical treatment of carcinoma of the breast are obtained from primary radical amputation. There are many variations in methods of carrying out the minor details of the radical amputation, but the fundamental principles of the operation are invariable and should be carried out in all cases accepted for surgical treatment. This initial treatment is by far the most important procedure, and the possibility of a cure depends on the thoroughness with which it is carried out. The importance of this cannot be overestimated, for minor operative procedures are rarely curative. I believe that one of the important factors in the unsatisfactory results obtained from surgical treatment is the relative frequency with which minor operations are done for malignant disease.

The greatest variation in technical procedures has been that pertaining to the type of incision to be utilized. This is important from the standpoint of local recurrence, but regardless of the type of incision which is utilized, the deep operative dissection must always be the same and constitutes a thorough block dissection of the underlying muscles, regional lymphatic vessels and nodes. I do not use a uniform type of incision, for I believe that the best results are obtained when the incision is planned so as to remove the greatest practicable amount of skin and subcutaneous tissue surrounding the lesion. If the incision is carefully planned according to the situation of the tumor, usually a sufficient amount of skin can be removed so that there is little or no danger of recurrence of the lesion in the skin. Skin grafting may be necessary for the more extensive lesions.

In general, if the position of the tumor is at 12 or 6 o'clock in the upper or lower half of the breast, a vertical incision will give the best results in the complete removal of the tissues surrounding the growth and in obtaining adequate exposure for the deep dissection. This vertical incision never extends beyond the point of the shoulder, as incisions which extend over the shoulder to the upper arm often result in restricted motion of the arm. The lower end of this incision extends over the upper portion of the epigastrium so as to give access to the lymphatic tissue and permit removal of the anterior fascial sheath of the rectus abdominis muscle. If the position of the growth is at 3 or 9 o'clock in the extreme inner or outer half of the breast, a transverse incision is usually best utilized, as this incision usually permits the removal of a large amount of skin and subcutaneous tissue around the diseased regions. This incision should be so planned that free access can be gained to the axilla as well as to the fascial sheath of the rectus abdominis muscle. Tumors situated in the upper inner quadrant of the breast present one of the most difficult problems from the standpoint of cutaneous incision. For lesions in this region I have suggested an incision that extends from the manubrium diagonally downward and laterally, making a median anterolateral type of vertical incision. This incision has proved very satisfactory in this type of case.

After the incision in the skin has been outlined carefully, the skin flaps are dissected from the underlying subcutaneous tissue. These skin flaps are prepared similarly to full thickness skin grafts, leaving only sufficient subcutaneous tissue (about 1 cm. in thickness) attached to the skin to maintain an adequate blood supply (Fig. 1). The dissection of the skin flap is carried out around the entire outlined operative field. The dissection of the median flap is carried to the midline; the lateral flap is dissected to just beyond the border of the latissimus dorsi muscle.

The deeper dissection is begun by splitting the pectoralis major muscle at the junction of its sternal and clavicular portions. The attachment of the sternal portion of this muscle, which constitutes about the lower two-thirds, is severed from its attachment to the humerus preparatory to its removal. The lymph nodes along the upper border of the brachial vessels are thoroughly removed and the dissection is carried to the lower border of the pectoralis minor muscle. This muscle is removed completely and its attachment is severed at its insertion to the coracoid process of the scapula (Fig. 2).

The dissection of the axillary, subclavicular and subscapular nodes is carried out in one mass. Care should be exercised to remove all of the lymph nodes and lymph-bearing fascia, both above and beneath the axillary vessels and nerves, as well as those contained in the infraclavicular fossa at the point where the axillary vein enters the thoracic wall. During this dissection it is advisable to preserve the long thoracic or external respiratory

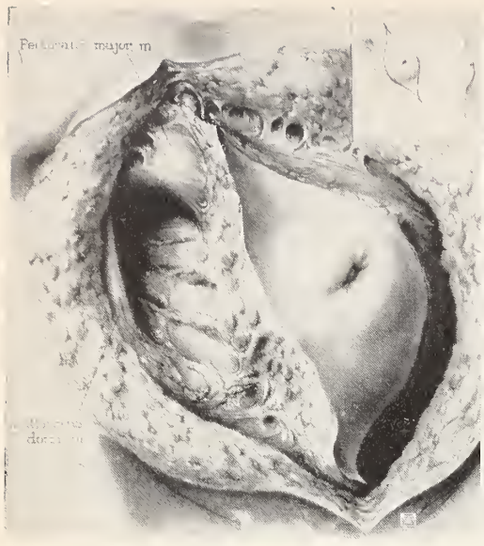


Fig. 1. Vertical incision with wide excision of skin and subcutaneous fat completed before deeper dissection. [From Harrington, S. W.: Carcinoma of the breast: surgical treatment and results. J.A.M.A., 92:208-213, (Jan. 19) 1929.]

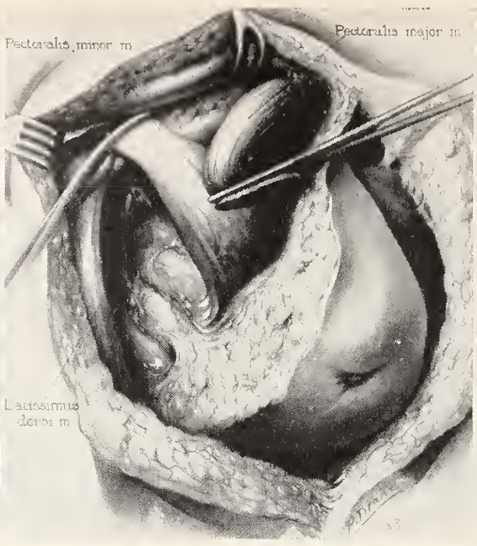


Fig. 2. Removal of pectoralis minor and greater portion of pectoralis major muscles to expose axillary lymphatics. [From Harrington, S. W.: Carcinoma of the breast: surgical treatment and results. J.A.M.A., 92:208-213, (Jan. 19) 1929.]



Fig. 3 Dissection of axillary lymphatics from the sternum toward the axilla: ligation of the branches of the axillary vessels. [From Harrington, S. W.: Carcinoma of the breast: surgical treatment and results. J.A.M.A., 92:208-213, (Jan. 19) 1929.]

nerve of Bell and the middle or long subscapular nerve to the latissimus dorsi. When possible, it is advisable to preserve the subscapular artery and vein which accompany this nerve, as the maintenance of this collateral blood supply is helpful in preventing swelling of the arm (Fig. 3).

The tissues to be removed which are still attached to the wall of the thorax include the breast, subcutaneous tissue, axillary, subscapular and subclavicular nodes and node-bearing fascia, the pectoralis minor muscle and the greater portion of the pectoralis major muscle with the accompanying sheaths, lymph vessels and nodes. The lateral portion of these tissues is then elevated and the structures are dissected from the wall of the thorax starting from the lateral aspect just above the border of the latissimus dorsi muscle, removing the fascial sheaths along the thoracic wall over the serratus anterior muscle, and the origin of the pectoralis minor and major muscles from the thoracic wall. The vessels from the internal mammary and intercostal vessels perforating the intercostal muscles are ligated close to the thoracic wall as the dissection proceeds. These vessels can be visualized as the tissues are elevated laterally before they are cut. The anterior fascial sheath of the rectus abdominis muscle is removed as the dissection proceeds toward the midline over the epigastrium, and all of the structures are removed in one mass (Fig. 4).

Great care should be exercised in obtaining complete hemostasis, and if the cutaneous flaps are properly planned, there should be a slight tension on the skin when closed so as to obliterate any dead space; this prevents the accumulation of blood or serum between the cutaneous flaps and the thoracic wall which would delay healing. Drains are placed in the axilla and at the lower angle of the incision. A pad is placed in the axilla to provide pressure and the arm is elevated to the position of a right angle and is maintained by pillows. The initial dressings are not disturbed for forty-eight to seventy-two hours, and the drains are removed on the third to fifth day.

Analysis of Data

I shall present first, some of the general considerations as to the types of malignant lesions, age distribution of patients and extent of the malignant lesions at the time of admission to the clinic and operation. In this study I have reviewed all of the cases encountered at the clinic in the thirty-four year period 1910 to 1943, inclusive; this comprises a series of 7,481 cases of malignant lesions of the breast in which radical mastectomy was performed.

Table I shows that two general types of malignant lesions may be found in the breast: carcinoma and sarcoma, with several subtypes. The different types of carcinoma are by far more common than those of sarcoma and comprise 99.4 per cent of all types of malignant lesions of the breast. The fact that adenocarcinoma constituted 97.9 per cent of the total malignant lesions and that metastasis

TABLE I. PATHOLOGIC DIAGNOSIS

Type of Lesion	Number	Per Cent
Adenocarcinoma	7,322*	97.88
Epithelioma	33	0.44
Paget's disease	79	1.06
Melano-epithelioma	1	0.01
Sarcoma	42	0.56
Carcinosarcoma	4	0.05
Total	7,481	100.00

*Includes 21 cases in which the pathologic diagnosis was made elsewhere.

TABLE II. METASTASIS ACCORDING TO AGE

Age in Years	Patients	With Metastasis	
		Number	Per Cent
10-19	5	1	20.0
20-29	119	53	44.5
30-39	947	562	59.3
40-49	2,321	1,359	58.6
50-59	2,075	1,307	63.0
60-69	1,310	778	59.4
70-79	349	170	48.7
80+	12	4	33.3
Total	7,138	4,234	59.3

TABLE III. INCIDENCE OF METASTASIS

Year	Patients	With Metastasis	
		Number	Per Cent
1910-1919	1,427	907	63.6
1920-1929	2,190	1,426	65.1
1930-1939	2,293	1,283	56.0
1940	285	139	48.8
1941	338	183	54.1
1942	292	149	51.0
1943	313	147	47.0
Total	7,138	4,234	59.3

The hospital deaths among the 7,138 patients were 51 or 0.7 per cent.

of this type of malignant lesion is prone to occur early, indicates the seriousness of malignant disease of the breast. The different types of sarcoma of the breast comprises 0.6 per cent.

That malignant disease is not confined to any definite period of life is evidenced by the age incidence in this series. Table II shows the distribution of the female patients with unilateral adenocarcinoma of the breast (7,138), according to age and in respect to the presence of axillary nodal metastasis. The youngest patient was sixteen years of age; the oldest, eighty-seven years. The decade of life in which malignant lesions of the breast occurred most commonly was from forty through forty-nine years. The decade of life from fifty through fifty-nine years showed the highest percentage of patients who had axillary metastasis at the time of operation (63.0).

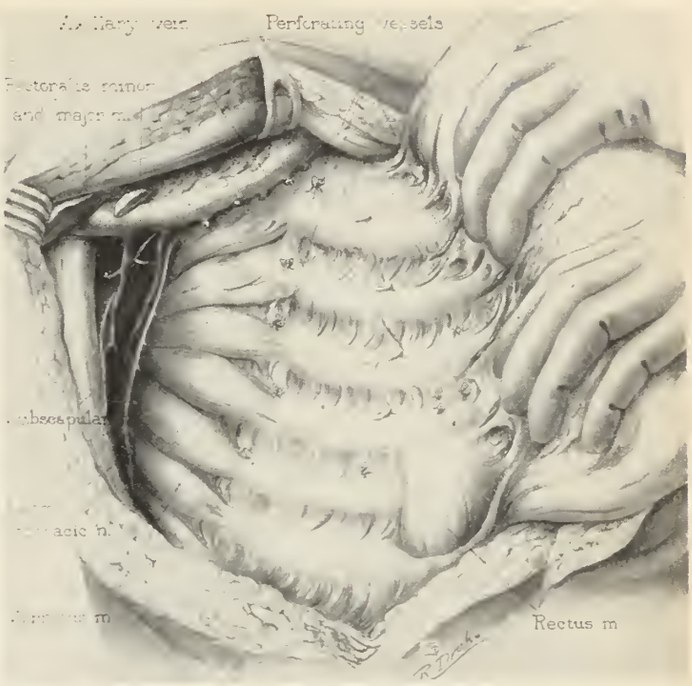


Fig. 4. Axillary dissection completed, the mass having been elevated toward the median line, the perforating vessels ligated and the anterior sheath of the rectus fascia removed. [From Harrington, S. W.: Carcinoma of the breast: surgical treatment and results. J.A.M.A., 92:208-213, (Jan. 19) 1929.]

Because of the importance of the extent of the disease at the time of operation, I have made a study to determine the percentage of patients encountered with axillary nodal metastasis in the thirty-four-year period, 1910 to 1943, inclusive. The results of this study show that in 59.3 per cent of cases, axillary nodal metastasis was found to be present at the time of radical mastectomy. The results of this study are very gratifying, as shown in Table III, in that, in the four years, 1940 through 1943, there has been a decrease below this average in the percentage of patients encountered who had axillary metastasis and in the year 1943, the lowest incidence of such cases, 47.0 per cent, was experienced. This is lower than the percentage of cases of axillary metastasis from carcinoma of the breast encountered in any previous year in the history of the Mayo Clinic.

The number of inoperable cancers of the breast that have been seen at the clinic during the last five years has remained fairly constant. There are varied opinions as to what constitutes operability. I shall state briefly the criteria of operability that have been followed in this series of cases. Any lesion of the breast was considered to be operable regardless of ulceration if it was freely movable from the thoracic wall. In some cases even if there were cutaneous nodules proximal to the tumor, regardless of the presence or absence of pal-

pable axillary lymph nodes, the lesion was considered operable. In addition, patients were accepted for operation if they had a diffuse type of malignant growth, if malignant disease was associated with lactation, as well as if malignant disease was associated with pregnancy. Those conditions were considered to be inoperable in which a large growth was fixed to the thoracic wall and there was very extensive metastasis to the axillary and supraclavicular lymph nodes or metastasis to other distant parts of the body. A few patients who had metastasis that involved distant portions of the body were accepted for operation because of exceptional circumstances.

As thus indicated, it is difficult to draw any sharp line between operable and inoperable lesions, and in each case treatment must be according to the findings. I have accepted for operation all patients to whom, I felt, there was a reasonable chance of offering comfort or greater length of life as well as those whose disease, I felt, stood a reasonable chance of being cured. It may seem that these rules of operability have not been drawn strictly enough and that cases have been accepted for operation in which the growth is too extensive. This is a matter of opinion, however, and justification has been found in many cases in which the condition was thought to be absolutely hopeless before operation but in which the patients have lived to enjoy many years of comfort.

A Study of the Survival Rates for Various Periods After Operation

A word about the way in which the calculations were carried out is in order. The records of patients who underwent operation the requisite number of years prior to the time of inquiry (January 1, 1944) were first selected. For the calculation of the three-year survival rate, the patients treated in 1940 or earlier were selected; for the five-year survival rate, those who underwent operation in 1938 or earlier were selected; for the ten-year survival rate, those who underwent operation in 1933 or earlier were selected and so forth. Obviously, then, the three-year survival rate was calculated on a larger number of patients than the five-year survival rate; the five-year rate was calculated on a larger number of patients than the ten-year survival rate, and so forth. Of the patients who underwent operation, anyone not traced for a sufficient number of years after operation was considered untraced, and was not included in the calculation of the survival rate. For instance, in calculating the five-year survival rate, a patient who had undergone operation seven years prior to the time of inquiry but had been traced for only four years after operation and who was living at that time, was considered untraced in the calculation of the five-year survival rate, because it is not known whether that patient did or did not survive until the fifth year after operation. For the purposes of the calculation of the three-year survival rate, that patient was considered traced, for it is known that the patient survived more than three years after operation.

When patients did not answer the routine follow-up letter, the local department of health, bureaus of vital statistics, and so forth, were consulted to learn whether any record of death existed. In the end, only a small fraction of the patients remained untraced. Ninety-seven per cent of the patients on whom operation had been performed three or more years before investigation, were traced for the requisite period.

In all of these statistical studies of survival rates it has been assumed that the patient died of malignant disease, although in many instances it was definitely known that death was due to other causes.

The first tabulation of survival rates was to determine the influence that axillary nodal metastasis, when found at the time of operation, had on the prognosis. The results are shown in Figure 5. The cases represented in this study comprise, for the calculation of the three-year survival rate, 6,511 patients with unilateral carcinoma of the breast on whom operation was performed in 1940 or earlier, of whom 6,318 (97.0 per cent) were traced. The graph gives the three-year, five-year, ten-year, fifteen-year and twenty-year survival curves for patients without and with axillary nodal metastasis as compared with normal life expectancy. There was a wide variation in the survival results and the prognosis was much better in those cases in which axillary nodal metastasis was not found at the time of operation than it was in those cases in which axillary nodal metastsis was found. The proportion of the group of patients who did not have axillary metastsis, living three years or more after operation, was 84.3 per cent, or almost twice as large as that for the group with axillary metastasis which was 44.2 per cent. For the five-year period, the survival rate for the group without metastasis was 75.8 per cent as compared with 30.7

TABLE IV. METASTASIS BY GRADE OF MALIGNANCY (BRODERS)*

Grade	Total Series		With Metastasis		Without Metastasis	
	Number	Per Cent of Total Graded Cases	Number	Per Cent of Respective Grade	Number	Per Cent of Respective Grade
1	396	6.5	13	3.3	383	96.7
2	770	12.7	262	34.0	508	66.0
3	1,980	32.6	1,247	63.0	733	37.0
4	2,927	48.2	2,407	82.2	520	17.8
Total Graded Cases	6,073	100.0	3,929	64.7	2,144	35.3

*In 1,065 cases grade of malignancy was not stated.

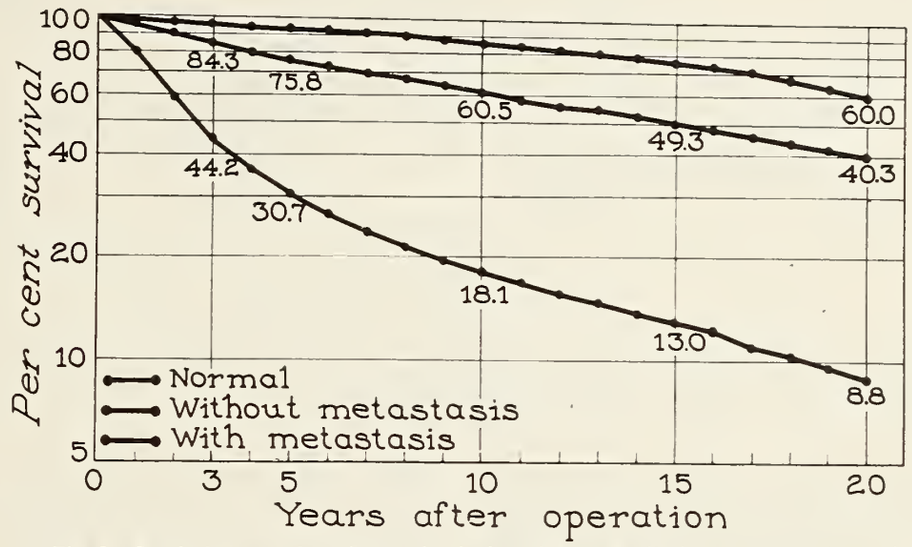


Fig. 5. Survival rates of patients who had undergone radical mastectomy for unilateral carcinoma of the breast with and without axillary nodal metastasis, as compared with normal life expectancy.

per cent for the group with metastasis. In the ten, fifteen and twenty-year survival rates of patients without axillary nodal metastasis, it was found that the improvement increased progressively over the group with axillary metastasis.

Although axillary nodal metastasis is only one of the factors that may indicate the extent of the disease at the time of operation, I believe that it is one of the most important factors indicating the prognosis following operation because of the great influence that it has on the survival rates. Because of this fact, in compiling statistical studies of survival rates of malignant disease of the breast, I believe that all cases should be divided into two main groups, those with and those without axillary nodal metastasis at the time of operation, and that statistical studies should never be based on a combination of the groups, without knowing the number of patients in each group.

A study was made to determine whether there was any difference in the results obtained in the different grades of carcinoma of the breast. I shall first give a brief summary of the grading of cases, which has been done according to Broders' method of dividing malignant lesions into four grades based on cellular differentiation. This part of the study is based on 6,073 cases, the total number that has been graded in the series of unilateral carcinoma of the breast in women. A study was also made to determine the percentage of cases in each of the four grades of malignancy and the percentage of each grade of malignancy with and without axillary nodal metastasis at the time of operation. The results of this study are shown in Table IV. It was found that 48.2 per cent, or nearly a half, of all cases of carcinoma of the breast in this series are of grade 4 malignancy, and that of all grade 4 lesions axillary nodal metastasis was found in 82.2 per cent at the time of operation. On adding the grade 3 and 4 lesions, it was found that 80.8 per cent of cases of carcinoma of the breast were of high-grade malignancy from which metastasis occurred early. This again emphasizes the seriousness of malignant disease of the breast in that the majority of the lesions are of a high grade of malignancy and present a high percentage of axillary nodal metastasis at the time of operation.

A study was then made to determine the sur-

vival rates for patients without and with axillary nodal metastasis according to grade of malignancy. The results of this study are shown in Figure 6. This shows a definite and uniform relationship between the operative results and the grade of malignancy, in that the lower the grade of malignancy the higher the percentage of patients alive three, five and ten years after operation. This was found to be true in both the group with and that without axillary metastasis.

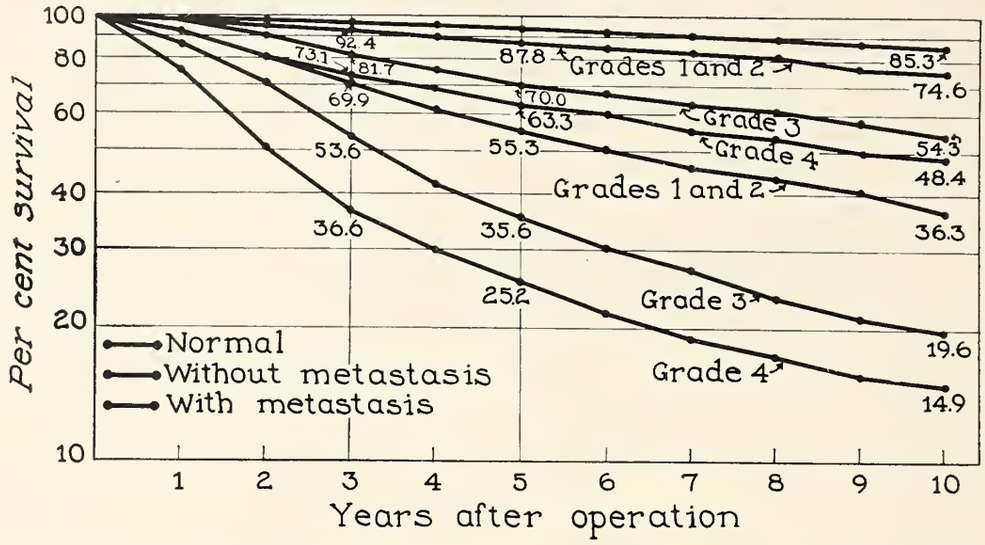


Fig. 6. Survival rates, by grade of malignancy of the lesion, of patients who had undergone radical mastectomy for unilateral carcinoma of the breast with and without axillary nodal metastasis, as compared with normal life expectancy.

It also shows, as was revealed in the previous study, that the surgical results are much more satisfactory in cases without lymphatic involvement than in those with lymphatic involvement in the same grade of malignancy. The study shows that the grading of malignant lesions gives a very important indication as to the prognosis. I believe that the grading of malignant lesions represents one of the greatest advances that has been made in the study of malignant disease in recent years.

A quinquennial study was made of unilateral carcinoma of the breast in women who had had radical mastectomy in the twenty-nine years, 1910 to 1938, inclusive. The last period is only four years (1935-1938) because patients who underwent operation in 1939 had not been operated on for a sufficient length of time at the time these statistics were compiled to enable five-year results to be compiled. This study was based on 5,558 patients of whom 5,407 were traced. The patients are divided into the two groups, those with and those without axillary nodal metastasis at the time of operation, as is shown in Table V. It was found that there was a consistent and appreciable improvement in the results obtained from radical mastectomy in each of the five-year periods. The study of patients representing axillary nodal metastasis at the time of operation in the five years, 1910 to 1914, inclusive, shows that 23.7 per cent were living five years after operation as compared with 39.1 per cent of those on whom operation was performed during the four years, 1935 to 1938, inclusive. In this study the results obtained among patients without nodal metastasis at the time of operation show a greater improvement in that there was 62.7 per cent of five-year survivals among those who underwent operation in the five years, 1910 through 1914, as compared with 81.9 per cent among those who underwent operation in the five years, 1935 through 1938.

A study of five-year survival rates following radical mastectomy for successive quinquennia was made to determine the results obtained for those patients with and without axillary nodal metastasis who had irradiation subsequent to the operation as compared with those who did not have irradiation subsequent to the operation. This study was made for the twenty-four years, 1915 to 1938, inclusive, since irradiation therapy was instituted as postoperative treatment in 1915. Table VI shows the results obtained from this study. In this study of cases with axillary nodal metastasis, it was found that the results in the different five-year groups were not uniform or consistent. In the five-year period from 1920 through 1924, the results were more satisfactory in patients who did not receive

TABLE V. FIVE-YEAR SURVIVAL RATES FOR DIFFERENT PERIODS OF EXPERIENCE ACCORDING TO METASTASIS

Period in Which Operation Was Performed	With Metastasis			Without Metastasis			Total Series		
	Patients Traced	Lived 5 Years or More after Operation		Patients Traced	Lived 5 Years or More after Operation		Patients Traced	Lived 5 Years or More after Operation	
		Number	Per Cent		Number	Per Cent		Number	Per Cent
1910-1914	300	71	23.7	212	133	62.7	512	204	39.8
1915-1919	586	155	26.5	292	211	72.3	878	366	41.7
1920-1924	650	155	23.8	356	252	70.8	1,006	407	40.5
1925-1929	750	245	32.7	395	305	77.2	1,145	550	48.0
1930-1934	607	213	35.1	396	324	81.8	1,003	537	53.5
1935-1938 (4 years)	455	178	39.1	408	334	81.9	863	512	59.3
Total	3,348	1,017	30.4	2,059	1,559	75.7	5,407	2,576	47.6

TABLE VI. FIVE-YEAR SURVIVAL RATES FOR DIFFERENT PERIODS OF EXPERIENCE WITH AND WITHOUT POSTOPERATIVE IRRADIATION

Period in Which Operation Was Performed	With Metastasis						Without Metastasis					
	With Irradiation			Without Irradiation			With Irradiation			Without Irradiation		
	Patients Traced	Lived 5 or More Years After Operation		Patients Traced	Lived 5 or More Years After Operation		Patients Traced	Lived 5 or More Years After Operation		Patients Traced	Lived 5 or More Years After Operation	
		Number	Per Cent		Number	Per Cent		Number	Per Cent		Number	Per Cent
1915-1919	361	101	28.0	225	54	24.0	165	119	72.1	127	92	72.4
1920-1924	595	140	23.5	55	15	27.3	263	182	69.2	93	70	75.3
1925-1929	665	220	33.1	85	25	29.4	247	193	78.1	148	112	75.7
1930-1934	561	199	35.5	46	14	30.4	284	233	82.0	112	91	81.2
1935-1938 (4 years)	435	173	39.8	20	5	25.0	325	266	81.8	83	68	81.9
Total	2,617	833	31.8	431	113	26.2	1,284	993	77.3	563	433	76.9

postoperative irradiation therapy than in those who received it. In the other four periods, the results were more satisfactory in patients who had postoperative irradiation than in those who did not have it and the total shows an improvement of approximately 5 per cent in those patients who had irradiation as compared with those who did not have irradiation therapy. The anomalous result in the five years, 1920 through 1924, is probably a variation of sampling, due to the small number of patients who did not receive irradiation.

It is to be remembered, however, that there is considerable difference in the total number of patients treated in each group, in that there were 2,617 patients with axillary nodal metastasis who were given irradiation therapy as compared with 431 patients who did not receive irradiation therapy. This difference in number is even more apparent in the different periods, a fact which would tend to favor a higher percentage of favorable results for those patients who were given irradiation therapy.

The results may be misleading for this reason as is shown in the four-year period, 1935 through 1938. Twenty patients were not treated with irradiation therapy and five (25 per cent) lived to the five-year period. A difference of one case in this small group would change this percentage 5 per cent. On the other hand, of 435 patients who were given irradiation therapy, 173 lived to the five-year period. Adding one case to the 173 cases, would make a difference of only 0.2 per cent.

There is also another factor to be considered in this study, in that irradiation therapy was given only as a routine postoperative treatment from 1925 through 1938. Those patients who did not receive irradiation were not treated because of some complicating general condition which makes the prognosis in this group less satisfactory.

In the study of cases without axillary nodal metastasis, it was found that there was practically no difference in the percentage of survival for five years after operation among patients who had irradiation when compared with those who did not have postoperative irradiation. The total percentage living in both groups was approximately 77 per cent and as shown in Table VI for each of the periods studied, the percentage of survivals was approximately the same.

This study shows that irradiation therapy has not been of any definite advantage in patients without axillary nodal metastasis.

It is difficult to evaluate the effect of irradiation therapy as an adjunct to surgical treatment of carcinoma of the breast, in studying the entire series of cases, because there are so many factors that influence the results of carcinoma of the breast. Among these factors are the extent of the disease at the time of the operation, the grade of malignancy, the presence of other associated conditions, such as pregnancy and lactation, the presence of other constitutional disease, such as diabetes, as well as the age of the patient. All of these different factors influence the prognosis regardless of whether or not irradiation therapy is instituted.

A true evaluation of irradiation therapy can be obtained only by comparing similar types of cases in which operation was performed. These studies of five-year survival rates indicate that there was some improvement in the results in those cases with axillary nodal metastasis when the radical mastectomy was followed by irradiation therapy but there was no appreciable improvement in the results when metastasis was not present at the time of the operation. At the present time irradiation therapy is given at the Mayo Clinic in all cases in which nodal metastasis is present at the time of operation unless it is contraindicated because of some general condition, but we are not giving irradiation therapy in those cases in which no axillary nodal metastasis is found at the time of operation.

These comparative studies are made every two to three years and the type of treatment employed depends on the results of the studies.

These studies indicate that the effectiveness of irradiation depends on the type as well as the extent of the disease and the most important consideration in the treatment of adenocarcinoma of the breast is a thorough primary radical mastectomy.

MSMS

Congressman Forest A. Harness—"The Bureau of Research and Statistics in our own Social Security Board in Washington is the world headquarters of Socialized Medicine . . . "world movement is paid for by the American taxpayers . . ." Government propaganda is a method of dictators. . . . "Our purpose will be to uproot and destroy government propaganda wherever we may find it."

Psychotherapy Aided by Meduna's Carbon Dioxide Treatment

By Paul H. Wilcox, M.D.
Traverse City, Michigan



PSYCHOTHERAPY is vaguely used by many, but its precise methodology has often been obscure. It has been understood in professional circles that one gets psychotherapy from a psychiatrist or a psychoanalyst, but their neighbors, the clinical psychologists and the psychiatric social workers, have often sought the privilege of adding psychotherapy to their activities. The area has been invaded by ministers, vocational counsellors, educators and others, though it might be said that the psychiatrists have invaded the area once held more exclusively by the clergy. It is therefore desirable to outline briefly the meaning and methods of psychotherapy.

In general, psychotherapy[1,2,5] may be defined as the treatment of persons, singly or in groups,[3] by verbal methods, supported by complex nonverbal cues. To say "treatment" implies that there are symptoms or deviations which need some sort of modification in the direction of better health. Since everyone has problems, there is some need for psychotherapy for everybody.

The first step in psychotherapy is to attempt to bring into focus just what symptoms are to be modified. There is a tendency at times to continue therapies without a clear idea as to what in the individual is being treated. The psychiatrist needs eternally to keep asking himself, "What am I trying to do for this particular patient? What barriers have been crossed today? What different approaches are needed for this individual today?" When the psychiatrist has brought the patient into focus, the important second step has been accomplished, namely, the establishment of a person-to-person relationship. The patient quickly realizes that the doctor is interested in him or her, and then comes the tussle of therapy.

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The dynamic stereotypies* of the patient and of the doctor come into some sort of competing relationship. It must be realized that neither the patient nor the therapist actually can do anything with any single unified purpose, both conscious and unconscious. The psychiatrist who has had sufficient training in his own personality processes will constantly see many of the components of his own personality reactions in the therapeutic situation and to that extent will be less deceived by his own projections. However, he should constantly appreciate the fact that every physician-patient relationship changes the physician as well as the patient, and if the physician is too stereotyped, his therapeutic success will be quite limited. At any rate, the relationship between physician and patient is more often competition of some kind than straight co-operation. When one speaks of a co-operative patient, one usually refers only to that patient's conscious willingness to co-operate with the procedures prescribed by the doctor. That same patient may have a very great unconscious resistance to any modification of the symptoms under attack. Thus, at times the doctor and the patient may feel that they are waging a common struggle against the vagaries of the patient's unconscious. At any rate, the psychotherapeutic situation involves co-operation here and competition there. The competition may be compared to a wrestling match in which the opponents seek out each other's weak spots.

The most usual, though often fruitless, method of psychotherapy is for the therapist to make a speech in which he offers ample advice, often without having first really found out much about the patient's problems. This procedure gives the therapist a splendid opportunity to project his own personal problems and his imagined solutions upon the patient and thus feel a sense of cathartic relief even if the patient does not share the benefits. If the therapist's patterns are not too stereotyped, he may discover that the patient has not been cured, but often the patient is dismissed with a feeling of disgust, "I hope I never see him again. It doesn't do any good to give him advice because he never takes it."

Assuming that the therapist has attempted to keep the patient and his problem in focus and assuming that the person-to-person relationship is not too clouded by the therapist's projections, the next step is to encourage the patient to express or "talk through" the conscious aspects of his problem. This form or phase of therapy may be adequate for some types of problems, and the patient gets a great relief from having found somebody who listens to his problems. The mere expression of them clarifies them and enables the patient to go about living with less handicap. This often is true in regard to topics which have been strongly tabooed so that the patient has found few or no previous opportunities to express himself before entering into the atmosphere of protection in the psychiatrist's confidence.

However, simple talking through of conscious problems often fails to bring adequate relief because the crucial factors may not be conscious. Another pattern of approach which can be tried at this stage is that of suggestion and reassurance. Suggestion therapy has been highly developed in hypnosis, and in modern practice hypnosis is being combined with analytic procedures[7] so that it is not merely a covering up of the problems.

After a relatively brief investigation of hypnosis, Freud abandoned it because he found that it often cleared a symptom without changing the basic problem and new symptoms sprang up to take the place of the old ones. He developed psychoanalysis, which is a method of bringing into consciousness the unconscious problems by what he called free association. In this procedure the patient starts out with talking through his conscious problems and then is encouraged to express the random thoughts that pop into his mind while he is in a somewhat passive state. Symbolic information including dreams and some behavioral patterns are also dealt with in this way. It was found that memories which had been suppressed could be brought into consciousness by this procedure, and when accompanied by an appropriate emotional discharge, basic relief of symptoms was obtained. The psychoanalysts have been able to explore and to formulate many important mechanisms of the conscious and of the unconscious and have traced symptoms to conflicts and repressions arising at all stages of development from birth on, or even before birth.

Most psychoanalysts have staked out their territory as including many of the psychoneuroses and, more recently, the so-called psychosomatic problems. They have failed to improve satisfactorily most of the schizophrenics, manic-depressives, and

*Dynamic stereotypy is a term adapted from Pavlov. See Wilcox, P. H.[6]

psychopathic personalities. However, orthodox psychoanalysis is too slow and too expensive for the masses who need psychotherapy. It is a therapy for the rich. There has been an increasing trend to find short cuts so that the therapy can be within the economic reach of more people.[1] A variety of accessory techniques have been introduced for more quickly crossing the barriers to the discovery of the problem and for speeding the therapeutic attack. Such accessory techniques include electroshock brain facilitation, narcosynthesis (intravenous barbiturate facilitation), hypnoanalysis, carbon dioxide dream facilitation and insulin coma therapy. Some of these procedures have made possible fruitful psychotherapy of the major psychoses. It may be well to consider that the primary therapy in all suitable conditions is psychotherapy and all accessory methods are for the purpose of facilitation, that is, of crossing the barriers to psychotherapy.

Carbon Dioxide Therapy

One of the physiological aids to psychotherapy now available is the carbon dioxide oxygen inhalation treatment. This therapy facilitates primarily the symbolic aspects of the patient's dynamic stereotypy. All components of the patient's reaction to the CO_2 situation are significant and tend to yield leads toward the patient's problems. In those patients who respond to CO_2 coma with a remembered dream, the sequences are more easy to follow, and the CO_2 stimulus pin-points the problem with surprising efficiency. Under this circumstance the unconscious reveals the emotional problems in the sequence of their importance.

The author has followed the technique described by Meduna[4] with slight modifications. Meduna in his preliminary series attempted to minimize the active psychotherapy and found that even when the physician merely recorded the dreams there was a definite trend for the patient to gain insight and gain relief from his psychosomatic symptoms. The author has adapted the procedure to a psychoanalytic† orientation to the extent that the patient is encouraged to talk through every aspect of the CO_2 experience and then cautious added interpretations are given to the patient. It has been observed that if it is possible for the patient to discover the main unconscious significance of the CO_2 dream experience and talk through the multiple applications in his life experience, then the succeeding CO_2 experiences progress to new topics. If, however, the CO_2 dream is inadequately understood, it conveniently tends to repeat in whole or in part so that both the patient and the doctor have evidence that the basic meaning has not been worked through. Often a considerable amount of emotion is released during the CO_2 experience and this has therapeutic value as emotional catharsis. It is also an aid in helping the patient realize directly the importance of the material that is coming through.

Briefly, the author's procedure is as follows:

1. Fill a 9-liter rebreathing bag with 20 per cent CO_2 and 80 per cent O_2.
2. Apply an anatomical face-fitting mask** to the patient.
3. Turn the valve so the patient starts breathing the mixture.
4. Count the respirations out loud.
5. At the tenth respiration turn on a small stream of straight CO_2 from a second tank through a tube and y-connection to the rebreathing bag.
6. Remove the mask when the patient appears well asleep, which is signalized by a beginning depression of respiration and the appearance of very slight tremors. This usually occurs in the 30's or 40's of the counting.
7. Wait quietly while the patient fully awakens, usually only one to three minutes after the mask is removed.
8. When the patient answer, "yes," to the low question, "Are you awake?" record everything the patient can report about the experience, encouraged by such questions as "What else?" or "What does this (indicating some point of the dream or behavior) bring to your mind?"
9. If it appears that the patient is ready for more general discussion of the experience this may be added.

The first treatment is prefaced by explanations as to the nature of the CO_2 and O_2, the stimulus to deep breathing which is expected, and the possible occurrence of a dream. A sample of five respirations of the 20-80 mixture is given the patient and a review of the points is again given in the attempt to encourage the patient to adjust

†The term "psychoanalytic" is used in the broader sense recently suggested by Franz Alexander.[1]

**A No. 164 Connell socket mask works well.

to the sensations of the CO_2 stimulation with a minimum of apprehension. A few patients will thresh around and cry out during the brief period of coma after the removal of the mask and therefore it is preferable to use a double bed of Hollywood type.

Meduna's report of indications, contraindications, and results is on the whole valid. This author began this therapy after personal instruction by Meduna in May, 1946, and since then has given over 2,000 of the treatments, sampling cases widely from his state hospital population and from out-patients. The procedure as described above has given more gains in the psychoses, especially as a supplement to the facilitative type of electroshock therapy, than Meduna indicates. However, it is a therapy well adapted to private office practice because of its simplicity and safety, its lack of hang-over, and its spectacular application to psychosomatic problems. Each treatment takes about thirty minutes for the CO_2 inhalation, the recording of the dream and minimal discussion. When important material is coming through it may be desirable to arrange extra sessions for more extensive discussion. The night dreams should also be inquired about because they frequentlly throw light on the CO_2 experience. At first daily treatments may be desirable, but the frequency can usually be reduced fairly soon. Most conditions require at least twenty treatments for an adequate result and the number may reach 100 or more in the more difficult cases. Even so, progress is many times faster than in strict Freudian psychoanalysis and the psychiatric-hours are much fewer. Statistical analysis of our results will be carried out in a later paper.

The following two patients illustrate how the CO_2 facilitates the emotional reorientation which is necessary for the subsidence of the presenting symptoms.

Case 1.—Our first patient for review illustrates the rapid progress of therapy which may occur when the dreams are relatively vivid and emotionally loaded, and when the patient is able to talk the experiences through to the related life situations. She had been prepared for this accelerated therapy by intermittent interviews with her family physician over a period of five years. The physician had been sufficiently aware of psychotherapeutic factors to have helped her work through a patient-physician transference period. The patient was a married woman of thirty-two, complaining of epigastric and rectal distress which she recognized as being on an emotional basis because adequate medical examinations had failed to reveal organic disease. In the preliminary interview, she admitted feelings of incompatibility with her husband and thought part of the difficulty arose from resentments toward her parents because of inadequate affection from them and because of overly severe discipline. However, she could not decide which factors were of significance in relationship to her presenting symptoms. During her first CO_2 coma she cried out a little and awoke remembering a dream scene at her grandmother's house just after her grandfather died. She had experienced a sense of acute loneliness in the CO_2 dream. As she reviewed her memories in relation to this scene which took her back to about the age of eight, she was prompted to give numerous details of the way her father and mother treated her. The loneliness was partly due to a lack of feeling of love from her mother and partly because she was left to keep her grandmother company for several weeks at a stretch, repeatedly, when she longed for the companionship of her playmates at home.

The second CO_2 treatment produced a similar degree of emotional response. The dream was again a scene from the same childhood period but this time the feeling was one of strong frank resentment toward her parents for the treatment she received. She recalled actual incidents when she would be punished unreasonably and she would say to herself that it would not do any good because she was going to repeat the act anyway. She said her mother never punished her but always had her father do it. He might be occupied with other matters when he got home but he would not forget that she had a spanking coming to her, even if it was all of a week later before he got around to it. At that late date she often would have forgotten what the spanking was for. She felt that her parents made a point of not granting her wishes on the theory that it would develop her self-discipline. When it came to courtship they disapproved of the boy she was really interested in but seemed quite pleased with one she only mildly care for. She felt it was less effort to go out with the boy they approved of and indulge in the phantasy that he was really the other boy than try to argue her parents into letting her go with the boy she really liked best. She developed the pattern of pretending she didn't care much about doing something she really wanted to do badly so that her parents would let her do it. All these details were correlated with the strong feeling of resentment she discovered in the CO_2 dream.

The third CO_2 dream was the feeling of pitching into space accompanied by a very acute feeling of hate toward her husband. This combination brought to her mind an experience only two years earlier when her husband had decided it was time to go home from a dance at 1 a.m. She did not want to leave that early but he put his arm around her and firmly led her out of the dance hall while she unobtrusively resisted. When they came to the top of a long flight of stairs she caught her heel on a step and it came off and she fell two steps. Even though she did not fall down the rest of the way there was the feeling of pitching off into space, accentuating her bitter feeling toward her husband for making her leave the dance hall. She re-

experienced in the CO_2 dream all the concentrated hate toward her husband that she had built up over the years beginning with the marriage she had accepted as a phantasy substitute for another man. She acknowledged that it was an awful way to feel about anybody but she was able to accept it without undue guilt feeling as a dream experience which had a certain objectivity in her personality.

The fourth CO_2 dream was somewhat similar in setting but this time the accompanying emotion was one of a feeling of revenge. She felt that she had done something to her husband in the dream to pay him back for something he had done. The details were not clear but she could recognize the feeling as a counterpart of her actual life relationships.

The fifth CO_2 dream was a scene of going down a long hill with a sense of fear and sexual anticipation mixed. After a little reflection she said, "I was wondering when that would come up, because it was so inevitable that it would have to come up about now."

Following this fifth treatment she was aware of renewed interest in her home. This degree of emotional recapitulation was achieved in five days, but she was continued on a weekly or bi-weekly treatment program to aid in the necessary reconstruction period. At this writing she has had ten additional treatments in the three months since the first week of intensive therapy. Her rectum has not given her pain and her epigastrium has not bothered her since that first week.

Her readjustment was achieved because she was able to re-experience the emotions of the childhood period and to recognize her relationships with her parents as past history which could be mellowed by mature perspective. She recognized that her husband had been a father substitute and that her marital problems were largely a displaced re-enactment of her childhood conflicts. She often had felt that her husband was overcritical of her. Now she admitted that he seldom did criticize her but that a word or two of criticism aroused in her the feelings of resentment previously created by the long tirades of her father. She was able to begin to rebuild her life in relation to the real person, her husband, whom she had never really seen before except through the haze of her phantasies. This reality adjustment will not be easy.

This is an unusual case in the rapidity of the recapitulation of the life problems, but the pattern is quite typical. It will be noticed that the CO_2 dreams in this case were more differential in their intense emotional components and less obscure than ordinary dreams at night. This is not always so because very obscure symbolism is often met with in CO_2 dreams. This case does illustrate the powerful emotional catharsis accompanying the CO_2 experience and illustrates the general pattern of psychotherapeutic approach.

Case 2.—Our second patient for discussion was more representative of the complexity and rate of progress of patients suffering from psychosomatic problems. She was given thirty-six treatments over a period of nine weeks. Her dream material, both under CO_2 and at night, was abundant. Therefore it can only be reported briefly in the space available here. She was a pleasant single school teacher of forty complaining of pains in the left side of her jaw, headaches, backaches, and pains in various joints, including her finger joints. The pains in her jaw joint had been particularly aggravating, coming in sharp flashes which would make her jump up from the table when eating. A dentist had undertaken to grind down some of her teeth as a remedy, but this gave no relief. The pains and aches in the muscles and joints had been variously diagnosed as neuritis, arthritis and rheumatism. She had begun to fear that she was destined for a life of progressive invalidism and pain as a chronic arthritic. Examination failed to reveal evidence of peripheral neuritis. X-rays did not show evidence of arthritic joint changes. The blood uric acid was low, thus eliminating the possibility of early gout. Her blood picture was normal.

She recognized the possibility that there might be a nervous component in her difficulties but she was not a self-pitying, complaining person. Her symptoms seemed primarily physical and she felt that the pains were making her nervous. Her personal history, as she reported it, did not seem too relevant. When she was only two weeks old her mother died. She was brought up by her grandmother in the midst of numerous relatives. She had been subject to a series of severe illnesses from childhood on. Two years ago a fibroid uterus necessitated a hysterectomy. About the same time her father died after having been incapacitated by a stroke for a number of months. She had no particular explanation for not having ever married, saying it just never turned out that way.

The treatment of this patient was undertaken with the recognition that there were probably deep-seated emotional factors which were mostly unconscious and it was explained that probably intensive treatment throughout the summer would be necessary. The longest interval between treatments was twelve days when she was out of town, but most of the time she had six treatments a week. Each session averaged about thirty minutes because of the quantity of material which was brought out each time. At the end of this period all her symptoms had subsided except for a slight twinge in her jaw occasionally, but some aspects of her personality readjustment were incomplete. However, it was judged that she had progressed sufficiently so that she could return to her teaching program with the expectation that her readjustments would continue in relationship to reality situations.

The long-hand notes on this case filled eighty pages and she brought in thirty-six pages of written-out night dreams. The first CO_2 treatment brought a surprise to both the doctor and the patient and was immediately convincing to the patient that her unconscious contained strong hidden emotions. While still asleep she whispered the story of her feelings. This is an uncommon reaction pattern but may have been related to a history of talking in her sleep. Her first whispered production was as follows: "Oh Mama, Mama––, why did

you die and let me live. Oh dear God. Mama, your little girl. Oh my Daddy. I don't want to live. My lovely, lovely mother, come get me, come take me. Well, the damn hospital. That's not news I knew that. I'm so silly. I'm so tired, Oh I'm so tired, Mama, come take me to my mother. I'm so all alone. Oh Mama, Mama (sobbing). Oh this is awful. Mama, I hurt. I'm so tired, cover me up mother, Mama come take me." At the end of this monologue she awakened with a quick transition and sat up and looked around. She explained that she had always called her grandmother, "Mama" and had referred to her dead mother as "Mother."

This theme of wish to join her mother in death persisted for several sessions. Then her relationship to her father became the central theme. She discovered that she had "big-sistered" her father most of her life even from late childhood. Her father was a small man and quite dependent and she really treated him as a little brother. This pattern had been extended to all people. The reason she had not married was that she had not allowed herself to become close to any boy or man she couldn't boss around as a little brother. Her night dreams revealed an evolution of her unconscious orientation to sex while her CO_2 dreams brought out a series of unconscious problem situations which required emotional adjustment in order for her to mature.

For instance, she had the following dream at night following her twentieth treatment: "I am working on a finger painting and taking care of an infant in a baby carriage. When I turn to tend the child an unseen hand scatters ashes on my work. The painting is pink. When I attempt to rub away the ashes they too become pink. This dream repeats itself numerous times." It was not difficult for her to discover by free association that the ashes were similar to the pistils of flowers scattered around in a previous dream and that pink represented "baby pink" to her. Also, she had recently teased a man about throwing ashes around the house, and at interview, she volunteered the question, "Is ashes a male symbol?"

During this period the CO_2 dreams expressed tension. During her twentieth treatment she whispered, "Pull me up, pull me up, why don't you help me." During her next treatment she whispered, "Oh my back, my back. Stop pushing me, you'll kill me." Discussion revealed a connection between her backaches and an occasion twelve years before when she had been knocked down and run over by a bicycle. She volunteered, "I feel scared when I see a child on a bicycle." During the twenty-second treatment she whispered, "Don't go, don't leave me—oh oh." Free association brought up: "I have felt it was unnecessary for my mother to have died. I was puzzled that I should have been left. When my father died I felt badly. I have wondered if I had been made to feel guilty because my mother died when I was born. I have a horrible feeling of not succeeding." During her twenty-sixth treatment she had a vivid emotional experience which was very unpleasant. "I think they were trying to take something away from me—a feeling I should keep something of mine. I was afraid. Whatever it was it must have been like a nightmare—it must have been horrible." The free association brought out the following: "I'm not in pain but I have a feeling as if I had been—as if somebody had squeezed my life out of me like you'd squash a grape. Seems like what I saw today is more awful than anything. When I was a child I used to imagine I had a couple of companions who lived in the attic, till I was about ten years old. I have often thought I was very happy with those two kids. I was going down town one day talking to my two pals and a man asked me where the other two girls were. That was the end. I'd gone too far. I decided I'd better kill the two and I did. I have been lonely in that respect. People didn't belong to me. The only things that were mine were within my own head. I don't think anybody could have shot those two girls quicker than I did that evening."

At this point in the interview her attention was directed back to the CO_2 experience and then she was able to identify the feeling. "I have always been hunting for something. I have been over-emotional and over-stimulated. Since my father's death two years ago I have been sick. I've been fighting sexual organ trouble. It is a tense feeling. I used to daydream. I'd build houses and put people in them. For a year now I don't know where to look or what to do. I'm frantic because I can't find myself. If I were forced to look at my own life in a dream stretching out in front of me, I would think it was horrible."

The connection between her hysterectomy and the cessation of her house-building phantasies was talked through. The general pattern of phantasy adjustments rather than reality adjustments was also talked through. For her to say that a look at her life stretched out before her would be horrible might suggest that the CO_2 experience would depress her. On the contrary, the recognition and expression of these feelings resulted in a relaxation of tension. In psychoanalytic literature there has been a word of caution about releasing the unconscious conflicts too rapidly for fear of precipitating a dangerous reaction. This is conceivably possible with CO_2 treatments, but actually has been a very uncommon problem. In panic states of psychotic or near psychotic proportions, the panic is sometimes increased for a few minutes after treatment. This tends to be less marked if the treatment is carried through to a fairly deep coma which allows a more active emotional discharge during the awakening, even to the point of loud outcries and vigorous rolling about. Such patients have claimed that they felt distinctly better after such a treatment than after a treatment which was terminated just before the loss of consciousness.

At any rate, our second patient did get considerable release of inner tensions, partial insight into her unconscious dynamic mechanisms, and an important gain in maturity as to sexual attitudes and reality adjustments. At the last treatment there was still evidence of unresolved inner tensions but a tally of her symptoms revealed that her headaches, backaches, and joint pains were gone. The pains

in her jaw were markedly diminished and she was aware only of a slight twinge now and then. She returned to her teaching position which meant going to another town and therefore also necessitated termination of the treatments. Undoubtedly, if it had been convenient, treatment would have been continued for a while longer.

Summary

1. Methods of psychotherapy are briefly reviewed.

2. Psychotherapy is presented as the dominant therapy in treating mental illnesses and psychosomatic problems, but various procedures are now available to facilitate the psychotherapeutic process.

3. Meduna's carbon dioxide therapy is briefly described and two cases are presented, illustrating the psychotherapeutic dynamics which were facilitated.

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MSMS

ARMY STATISTICS

In World War I, battle deaths were 16.4 per thousand troop strength; nonbattle deaths 17.9; deaths from disease 16.5, and deaths from wounds 4.4, while in World War II battle deaths were 9.7 per thousand troop strength; nonbattle deaths 2.9; deaths from disease 0.6, and deaths from wounds 1.1.

TEN DOCTORS NEEDED IN MICHIGAN

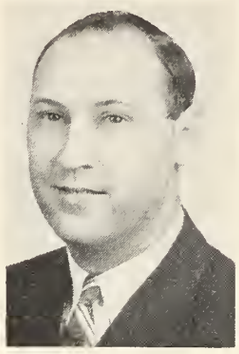
The manager of the Veterans Administration office in Grand Rapids, Michigan, has requested county medical societies in that area to co-operate in obtaining the services of ten physicians, who will be selected to serve as members of rating boards to determine the degrees of disability incurred by veterans during military service. According to the Grand Rapids Michigan Press in addition to the salary these positions provide for twenty-six days' annual leave with pay. Applications should be forwarded at once to the Personnel Division, Veterans Administration, Guardian Building, Detroit.

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Reiter's Syndrome

By Russell F. Wiggers, M.D.

Flint, Michigan



REITER'S SYNDROME is the name given to the symptom-complex of a non-specific urethritis, arthritis, and conjunctivitis.

This condition was first described in 1916 by Reiter in Germany, who believed it to be a spirochetal disease. In 1942, Bauer and Engelman of Boston described and reported the first cases in this country. Since that time it has been reported with increasing frequency in the United States. The largest number of cases studied so far was a group of fifty-three at Ashburn General Hospital by Hollander and his associates.

The syndrome is relatively infrequent, a total of slightly over 100 cases having been reported. The majority of these were in soldiers of both World Wars. The diagnosis is frequently missed. This is due to the resemblance of the syndrome to other more common diseases, to the diversity of organs and systems involved, and to the general lack of knowledge and acquaintance with the disease.

As yet our knowledge of the condition is meager. For this reason every opportunity should be taken to study and report these cases when they arise. Only by this procedure will the true nature of the disease become apparent.

Case Reports

Case 1.—P. G. (No. 218998), a twenty-seven-year-old white male laborer of Spanish descent, was perfectly well until five days before admission, when he developed a painful red swelling of the left ankle. Associated with this was a feeling of general malaise and weakness. There was no chill. The pain and swelling subsided somewhat during the next three days. The day before admission the right knee began to swell. This was followed very shortly by painful swelling of the left knee. At the same time he noticed a purulent discharge from the urethra. There was no pain associated with the discharge. He denied having had sexual relations for the previous two months.

The past history revealed that two years previously

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he developed painful swollen joints associated with a penile discharge. Both disappeared within two to three weeks, and were not serious enough to confine him to bed or to cause him to seek medical attention. A bilateral saphenous vein ligation was performed several years earlier. Childhood diseases were denied. There had been no accidents or operations. At no time had he had conjunctivitis or eye infection. There was no history of rheumatic fever in himself or his family. Venereal infection was denied. Review of systems revealed a slight loss of appetite since the onset of the presenting illness, and a weight loss of 6 pounds in the two weeks preceding his admission.

The family history was irrelevant.

Physical examination revealed an acutely ill male, temperature 100.3°, pulse 100. The skin was warm and moist. The head, neck, eyes, ears, nose and throat were negative. The lungs were clear. The heart was not enlarged. There were no thrills, shocks, or murmurs. The rate and rhythm were normal. Blood pressure was 110/70. The abdomen was symmetrical, soft, and relaxed. The liver and spleen were not palpable. Examination of the genitalia revealed a creamy urethral discharge. There were bilateral saphenous vein ligation scars, with evidence of old, healed varicose ulcers. Rectal examination was negative. The prostate was normal.

The left ankle joint and both knee joints were swollen, red, warm and tender. Movement was painful and limited. There was slight boggy swelling of the dorsum of the left foot. The neurological examination was normal.

Admission laboratory studies revealed 85 per cent hemoglobin, 4,480,000 red blood cells, 20,600 white blood cells, with 68 per cent polymorphonuclear leukocytes, 31 per cent lymphocytes, and 1 per cent monocytes. The urine showed 2-plus albumin with 10 to 15 pus cells per high power field. The specific gravity was 1.012. There was no sugar present. The Wassermann and Kahn reactions were negative. The sedimentation rate was 34 mm. in an hour (Wintrobe).

Microscopic examination of the urethral smear revealed no pus cells or organisms. Culture was negative. X-rays of both knees were normal. Microscopic examination of fluid aspirated from the knee joints revealed a few pus cells. Culture was negative. Repeated blood cultures were negative. The complement fixation test for gonococcus infection was negative. Blood urea nitrogen was 10.9 mg.

During his hospital stay the white blood count varied from 11,800 to 20,600 with polymorphonuclear leukocytes predominating. The sedimentation rate was always elevated, the lowest reading being 25 mm. in an hour.

A short course of penicillin was administered without apparent effect. The urethral discharge cleared spontaneously after a few days.

During the twenty-three days of hospital residence the temperature fluctuated between 102.2° and 98.6°. The pulse remained about 100 per minute. Painful swelling developed in both elbow joints. This was accompanied by dysuria and terminal hematuria.

Treatment consisted of salicylates, heat, and massage. The joints remained slightly swollen and painful. He was discharged with only slight improvement.

He re-entered the hospital approximately four weeks later. During the interim, painful swelling of both knees continued. Two weeks before his second admission both wrists began to swell. On admission both wrists, as well as both knees, were swollen and tender. There was no urethral discharge. The rest of the physical examination was as on the first admission. The sedimentation rate was still elevated, as was the white blood count. The urine had cleared and was essentially normal.

Prostatic massage was done and smears and cultures were negative. No pus cells were found in the smear. The temperature ranged from 98.6° to 99.8°. An electrocardiogram revealed a normal rhythm. The P waves were a little notched in all leads. PR interval was within normal limits. QRS complexes and interval were normal. No axis deviation was present. The ST segments were iso-electric and a little cove-shaped in leads I and II. T waves were negative in leads I and II and diaphasic in lead III.

Six days after admission he was transferred to the county infirmary. While there muscle atrophy of the legs was noted. The temperature remained normal. He gradually improved and was encouraged to move and walk about. Massages were continued. He was able to return to work asymptomatic about five months after the onset of the illness.

Follow-up revealed him to be in excellent health with no sign of his former illness.

Case 2.—R.T. (No. 609284), a twenty-one-year-old Navy veteran was perfectly well until January, 1946, at which time he developed a painful, red, tender swelling of the right ankle. This was accompanied by a genito-urinary infection with frequency, urgency, pyuria, and hematuria.

He was in a Navy hospital from March until September, 1946. During the hospital stay the arthritis spread to the knee, ankle, hip, wrist, elbow, finger, and sacro-iliac joints. The involvement was asymmetrical. There was no response to salicylates, penicillin, sulfa, or typhoid therapy.

Shortly after the onset of the arthritis he developed a conjunctivitis of the right eye which lasted about one week. A balanitis circinata type of penile lesion developed and lasted about two weeks. This recurred twice. All occurred during the acute phase of the arthritis.

He developed ulcerations on the plantar surfaces of both feet. Later they progressed to hyperkeratosis of the soles of the feet with resulting desquamation of large areas of skin. Abscesses developed under the nails of the toes and fingers resulting in the loss of the nails.

The genito-urinary infection was diagnosed as cystitis. This lasted about four months and did not respond to any type of therapy.

During the hospital stay he lost weight, going from 158 pounds to 98 pounds. Severe muscle atrophy of the extremities developed.

All diagnostic procedures for the causative organism were negative. An elevated sedimentation rate and white count were the only abnormal laboratory findings.

The past history revealed that he had gonorrhea in 1944. It responded well to penicillin. As a child he had measles, whooping cough, mumps, rickets, and pneumonia. There was no history of rheumatic fever. There were no operations or accidents.

The family history was irrelevant.

At the time he was seen last, the right ankle and the first interphalangeal joint of the left middle finger were swollen and painful. There were multiple abscesses under the toenails. There was no muscle atrophy. There was a mild chronic prostatitis. The remainder of the physical examination was negative.

X-rays revealed some soft tissue swelling of the interphalangeal joints of the hand and of the right ankle. There was a destructive process involving the right sacroiliac joint and the interphalangeal joints of the right second toe, which was somewhat suggestive of septic arthritis.

The blood count was normal. The urine was normal. The sedimentation rate was moderately elevated.

Cultures of the prostatic fluid were negative.

Since he left the navy hospital, his course was one of gradual improvement.

Comment

Case 1.—This is a typical case of Reiter's syndrome. The onset and course, with completely negative bacteriological studies and the complete disappearance of all symptoms with no residual damage despite specific therapy, make the diagnosis relatively positive. From his history we may assume that he had a previous attack and that this may well have been a recurrence.

Case 2.—This case appears to be a severe case of Reiter's disease. The acute onset of arthritis associated with a genito-urinary infection, which might well have been a urethritis, and the later development of a conjunctivitis, satisfies the requirements of the triad. The diagnosis is further confirmed by the presence of balanitis circinata and hyperkeratosis of the feet.

The x-ray findings indicate that in all probability he will maintain some residual damage to his joints. However, at the present he is gradually improving.

Etiology

Reiter originally discovered a spirochete in the blood, which he named spirocheta forans. The subsequent investigators have failed to demonstrate this organism as the causative agent of the disease.

Beiglbock believed the condition to be fundamentally an allergic manifestation, but this is still unproven.

Most investigators believe it to be of infectious origin because of the nature of its onset and subsequent course. Various organisms have been suggested as the causative agent; namely, a staphylococcus, an enterococcus, a filterable virus, and a pleuro-pneumonia-like organism. None of these has been confirmed, and the etiology to date is undetermined.

The portal of entry is likewise unknown. Most cases start with urethritis, some with arthritis, a few with conjunctivitis, and still others with diarrhea. Not all cases have the typical triad of urethritis, conjunctivitis, and arthritis. Less than one-half the cases develop conjunctivitis.

Hollander has suggested the term infectious ur-arthritis, and compares it to gonorrhea. He believes that both conditions are closely related, and may cause the same group of symptoms. He suggests that chronic nonspecific ur-arthritis could cover both chronic rheumatoid arthritis in which there was a genito-urinary focus of infection, and the so-called postgonorrheal rheumatoid arthritis, which is so often accompanied by a chronic prostatitis in which the gonococcus can no longer be found.

Pathology

Because so little is known of the pathogenesis of this disease, it is difficult to determine just what are manifestations and what are complications. There is often extension of the disease process to a number of adjacent organs, and these may be severe enough to dominate the clinical picture.

There are only two constant findings in the syndrome, urethritis and arthritis. The urethritis may spread to produce prostatitis, prostatic abscesses, or vesiculitis. Hemorrhagic cystitis and terminal hematuria are frequently seen. Hydronephrosis, with hydroureters and pyelonephritis have been described. This is apparently not due to blockage, and the cause is undetermined. About 50 per cent of the cases develop a superficial ulceration of the glans penis or prepuce, which is characteristic of balanitis circinata. This has a tendency to recur.

The arthritis is of the polyarthritic type affecting primarily the larger joints. The distribution may be either symmetrical or asymmetrical, and both sides are involved equally.

Osteoporosis of the bone ends may appear about two months after the onset. This is spotty and never sharply defined. In a few cases periosteal proliferation near involved smaller joints, or actual bony destruction may occur. There is usually muscle atrophy. In the majority of cases

there is a gradual return toward normalcy of all the bone and joint pathologic processes.

Biopsy of joint tissues during the acute stage of the disease reveals reddish, purple congested synovia. There is no gross thickening. Several small, white, circumscribed areas of fibrous-like material may be found on the floor of the synovium. The cartilage appears normal.

Microscopic study shows an intense inflammatory reaction of the synovia, which is limited to the superficial layers only and doesn't involve the supporting structures. The blood vessel walls are normal. The synovia is thrown into large club-like projections in which abundant capillaries are dilated. Each projection is distended by a heavy lymphocyte infiltration mixed with a few plasma cells and neutrophils. There is no fibrous exudate present. There are no new capillaries, and the hyperemia consists of dilatation of the pre-existing ones.

The ocular manifestations include purulent conjunctivitis, superficial keratitis, iritis, episcleritis, iridocyclitis, subconjunctival hemorrhages, and herpes of the cornea. All cases have shown complete healing of all ocular manifestations with no residual damage.

Skin lesions have been described in a number of cases. The majority were of the keratodermia blennorrhagica type, and involved mainly the legs and feet. However, lesions may develop anywhere. The lesions start as deep-seated vesicles in clusters usually on the plantar surface of the feet. They enlarge and ulcerate. Later they become dry and crusted, and fall off leaving a dry and keratotic bed. These lesions usually appear about four to six weeks after the onset of the arthritis, and tend to clear up and disappear in about two months. Other skin lesions described are erythema multiforme, subungual abscesses, and superficial exoriations of the mucous membranes of the mouth and pharynx.

Clinical Features

The disease occurs in young males between the ages of eighteen and thirty-eight. Except for two cases in natives of the Bahamas, all are of the white race.

The only constant findings that need be present to make the diagnosis are nonspecific urethritis and arthritis. However, Jackson reported one case in a Bahaman who had no urethritis. In some cases there may be an associated diarrhea.

The majority of cases give no history of previous joint disease in themselves or their family. Sexual exposure in the month preceding the onset of the disease is denied by most.

The typical onset is acute with the development of nonspecific urethritis, which may be accompanied by a diarrhea of short duration in some cases. Usually within two weeks arthritis develops, and shortly thereafter a conjunctivitis may appear. The conjunctivitis is usually transient, clearing up spontaneously within one to two weeks, usually three to four days. The urethral discharge may be mucoid at first but later becomes purulent. This also is transient, lasting from a few days to three or four weeks, and is not affected by treatment. The discharge has a tendency to recur. In some cases prostatitis or prostatic abscess develop. Smears and cultures of the discharge are entirely negative for organisms.

The onset of the arthritis is accompanied by an elevation of temperature and generalized malaise. Night sweats are not uncommon. The chill which is so frequent with the onset of an acute specific arthritis is absent. The larger joints are most often affected, with the feet, ankles, and knees predominating. The wrists, fingers, elbows, shoulders, hips, mandibular, sterno-clavicular and spinal joints may be involved. The joints become warm, red, swollen, and tender. The involvement is asymmetrical. If the arthritis is the initial symptom, the urethritis usually develops within a few days. The time required for the complete clinical picture to develop may vary from two or three to forty or forty-five days, with an average of fifteen.

About one month after the onset there may develop superficial ulcerations on the glans penis or prepuce, characteristic of balanitis circinata. In some cases a keratodermia also occurs at this time.

During the acute stage the white blood count is elevated to between 10,000 and 20,000, and the sedimentation rate is increased. The sedimentation rate remains rapid and reaches its peak about six weeks after the onset, at which time the urethritis and conjunctivitis have disappeared. and the joints are less inflammed.

The peak of the acute phase is reached in four to six weeks, when the joints become less acutely inflamed. Joint fluid usually accumulates which is purulent and contains from 9,000 to 17,000 white blood cells per c.c., of which 65 to 75 per

cent are polymorphonuclear leukocytes. The arthritis now runs a rather protracted course with some remissions and exacerbations of pain and swelling. Muscle atrophy develops. During this time there may also be recurrences of the urethritis or conjunctivitis. The arthritis gradually clears up and usually there is no residual damage. The balanitis, when present, clears of its own accord in about one month, but it has a tendency to recur. Dark field examinations, smears and cultures of these lesions are always negative.

In about 10 per cent of the cases a keratosis develops; vesicles form which crust and eventually drop off. The feet and legs are the usual locations, but they may occur anywhere. They are characteristic of keratodermia blennorrhagica. Originally these were thought to be specific gonorrheal lesions. Clearing usually takes place within two months and there are rare recurrences. Other skin lesions described as occurring in Reiter's disease are erythema multiforme, hemorrhagic and purpuric lesions, and superficial excoriations of the mucous membranes of the mouth and pharynx.

The duration of the disease varies. After the acute phase has passed, there is no further progression of the arthritis to new joints. The joints gradually return to normal. The sedimentation rate returns to normal in about three to four months. The patient becomes asymptomatic anywhere from three to nine months after the onset. The average duration is six months. Recurrences of the arthritis develop in about 15 per cent of the cases.

Residual damage is not common. An occasional case with residual bony destruction of small joints has been reported.

The electrocardiogram is usually noncontributory. Two cases with a prolonged PR interval during the acute phase have been reported. These returned to normal within three to five months.

Laboratory

To date, most of the laboratory results have been disappointing and are helpful only in ruling out other disease entities. Smears and cultures of the urethral discharge, prostatic secretion, conjunctival discharge and joint fluid reveals no bacteria or causitive organism. The gonococcus complement fixation test is negative. Blood cultures are likewise negative. Conjunctival scrapings reveal no inclusion bodies. The urine shows pus cells, and occasionally a few red cells, but is negative on culture. Guinea pig inoculation with urine, joint fluid and urethral discharge is negative, for the tubercle bacillus. Blood agglutinations for undulant fever and the typhoid group are likewise negative. Skin tests for Chancroid, lymphopathia venereum and brucellosis are negative. Cultures and smears of all the superficial lesions reveal no organisms.

The sedimentation rate is elevated. The white blood count varies between 10,000 and 20,000.

X-rays reveal evidence of soft tissue swelling, and the presence of joint fluid. Some of the cases show osteoporosis of the bone ends, which is spotty and not sharply defined. A few cases revealed some periosteal proliferation. One case developed a spindle-shaped deformity of the fingers with joint narrowing and destruction similar to that seen in rheumatoid arthritis. Follow-up x-rays reveal a return to normal in practically all cases.

Diagnosis

Reiter's syndrome should be suspected in every case of arthritis occurring in young adult males. The patient must be closely questioned for the previous presence of a urethral discharge or conjunctivitis. Most patients are reluctant to admit having a discharge for fear that it is of venereal origin. The abrupt onset of the disease with urethritis, with or without a diarrhea, and the arthritis, should make one suspect this condition. If this is followed with a conjunctivitis which disappears without treatment, and if all the bacteriologic studies are normal, the diagnosis is fairly well established. Many cases will not be diagnosed until late in the disease when skin lesions and balanitis develop. There will be a few cases in which the diagnosis is made in restrospect only after a thorough study of the case.

Specific therapy should be withheld if no offending organism is identified.

The differential diagnosis usually lies between gonorrheal arthritis, rheumatic fever and rheumatoid arthritis.

In gonorrheal arthritis there is usually a definite history of sexual exposure, and the organism is found in the urethral discharge. The arthritis usually follows the urethritis in from one to four weeks, and tends to be monarticular in type. The joint fluid practically always reveals the organism on smear or culture. The gonococcus complement-fixation test is positive in 85 per cent of the cases. Joint destruction is common and the disease usually

responds well to antibacterial therapy. The initial temperature rise, white blood count, and synovial fluid counts are higher than commonly found in Reiter's disease. Recurrences are not common.

The patient with rheumatic fever often gives a family history of the disease. There is usually a respiratory infection followed by migratory polyarthritis with only transient joint involvement. There is no urethritis or conjunctivitis. There is often involvement of the heart. There may be electrocardiographic changes. There are frequent recurrences. The history usually reveals a previous attack at a somewhat earlier age. Salicylates control the fever, while helping the pain. Skin lesions when present are of the erythema multiforme, marginatum or nodular type.

In rheumatoid arthritis the incidence is higher in females. A family history is often present. The onset is more likely to be insidous with gradual spreading to additional joints. If acute, there are usually chills. The joint involvement tends to be symmetrical. There is no urethritis or conjunctivitis. The disease is chronic, progressive and destructive. Multiple deformities usually occur.

Complications

The most common complications are prostatic abscesses, prostatitis, and vesiculitis. They usually result from a spread of the infection backward from the urethra. Cystitis and hydronephrosis when present are probably complications. Their method of development is not known.

Ocular complications include superficial keratitis, iritis, episcleritis, iridocyclitis, and subconjunctival hemorrhage.

Subungual abscesses should probably be classed as complications.

Treatment

Many drugs have been tried in the treatment of this disease, but so far all have failed. The list includes sulfonamides, penicillin, neoarsphenamine, gold salts, and cholchicine.

Salicylates give some relief of the pain, but do not materially alter the course of the disease.

Typhoid fever therapy has been used with good results in the treatment of the ocular complications.

The best results are abtained by immobilization of the joints during the acute phase, followed by early mobilization with physical therapy as soon as the majority of the pain has subsided. Exercises, hot packs, and massage help prevent deformities due to muscle spasm. There should be no prolonged bed rest, the patient being urged to use his limbs as soon as the acute phase is over.

If the pain is severe, narcotics may be used.

Prognosis

The prognosis in most cases is excellent. Occasionally a severe case will result in a residual deformity.

Conclusions

Reiter's syndrome is being diagnosed more frequently. It should be considered in the differential diagnosis of every case of arthritis.

The disease may exist in a number of forms. The conjunctivitis and perhaps also the urethritis may be absent.

Close co-operation between dermatologist, urologist, ophthalmologist and internist is necessary in order to see and understand the complete clinical picture of this diverse disease.

Two additional cases of Reiter's disease have been presented, along with a review of the literature.

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Mr. Rollen Waterson, Executive Secretary, Alameda County Medical Society—"The 'Public Relations' of the profession is merely the computation of the incidence of good and bad relations between individual doctors and individual people. . . ." Here, truly, is the job which must be done . . . "to learn prevention and cure of bad doctor-patient business relations, and to teach doctors what has been learned." . . . "Employed Public Relations experts can't have relations with people *for* you."

B. Coli Meningitis in the Puerperal State

Report of Two Cases

By Kathryn J. McMorrow, M.D., M.P.H.
and
Franklin H. Top, M.D., M.P.H., F.A.C.P.
Detroit, Michigan

THE RECOVERY of a patient treated with penicillin prompted the reporting of the two cases of B. coli meningitis which have been seen at the Herman Kiefer Hospital since 1930. Of the cases of B. coli meningitis reviewed by Barrett et al (1942)[1] 100 had been treated before the advent of the sulfonamides, and among these there were seventy-eight fatalities. Stallworthy (1943)[5] reported two fatalities without the use of sulfonamides.

Barrett et al[1] also reported six patients treated with sulfonamides with one death. Kohlbury (1942)[3] and Crawley (1946)[2] reported one recovery each, while Pearlman and Bell (1944)[4] reported a fatality.

The first patient in this report received no sulfonamide or antibiotic therapy and did not survive. The second patient, treated with penicillin, recovered. In addition to recovery in one, these patients are of further interest because the pathogenesis was the same in both, namely, puerperal endometritis, septicemia and secondary meningitis.

Case Reports

Case 1.—On July 8, 1930, following three days of difficult labor, a twenty-six-year-old primipara was delivered by mid-forceps and episiotomy, of a full-term infant who died within a few hours of birth as the result of intracranial hemorrhage. On the second postpartum day the mother complained bitterly of severe headache and pain in the eyes. She had been running a steady fever (102° F.) since admission. By the sixth postpartum day the episiotomy wound had broken down and the sutures were removed. The patient continued to suffer severe headache and pain in the eyeballs. On the ninth postpartum day she became nauseated and vomited several times. The temperature rose to 103° F. She became irrational on several occasions during the next three days, and by the twelfth postpartum day she had developed a stiff neck. The patient was transferred to the communicable disease pavilion. A lumbar puncture was performed, and 30 c.c. of cloudy fluid were removed under marked pressure; 15 c.c. of antimeningococcal serum were given intrathecally. The white blood count was 14,000.

A second lumbar puncture was done on the thirteenth postpartum day. This time no serum was introduced intraspinally because gram-negative bacilli had been noted on direct smear the day previously. The organism proved on culture to be E. coli. The blood culture remained sterile. Urine cultures were not done but all catheterized urine specimens were normal. The patient's condition remained critical. Two lumbar taps were done on the fourteenth postpartum day with the hope of relieving pressure but no improvement resulted, and she expired the evening of that day. Consent for autopsy was denied.

Case 2.—On April 29, 1945, a thirty-five-year-old woman was admitted seven days postpartum, critically ill with a purulent meningitis. She gave the following history: On March 31, the patient developed cramps and a sanguinopurulent flow associated with arthritic and muscular pains, for which she spent the following ten days in a hospital. During that period she had two severe chills, inordinately severe backache and cramps, but was discharged with the threat of abortion allayed. Within twenty-four hours of dismissal from hospital the patient developed a bloody vaginal discharge and passed an "after-birth." She returned to the hospital with a complaint of fever, headache, general muscular aching, and abdominal cramps. On examination, the patient was found to be in labor. The morning after second admission to hospital, a four-and-one-half month fetus was passed with secundae intact. The patient became confused, very weak and complained of persistent backache and stiff neck. Shortly thereafter, she lapsed into coma.

A lumbar puncture revealed a purulent cerebrospinal fluid with a cell count of 2,680, all polymorphonuclear leukocytes. On April 17, penicillin therapy was begun; 20,000 Oxford units were administered every three hours intramuscularly with no apparent improvement during the next two days. On April 19, the patient was transferred to the communicable disease service. The patient was conscious on transfer but had classical signs of meningitis and showed an associated purulent conjunctivitis.

At this time, lumbar puncture revealed a cloudy fluid with a cell count of 620. Penicillin (10,000 Oxford units) was instilled intrathecally and intramuscular penicillin was given in amounts of 10,000 Oxford units every three hours. Daily intrathecal penicillin therapy was continued until April 24 and intramuscular penicillin was discontinued April 27. The cerebrospinal fluid findings are shown in Table I.

On April 24, there were E. coli reported in the spinal fluid; blood cultures showed no growth. Intrathecal penicillin was discontinued, and sulfadiazine was begun parenterally. On April 26, the blood sulfadiazine level was 12 mg. per cent. The patient vomited and was extremely irritable. On April 27 the patient complained bitterly of a stiff sore back, became apathetic, and continued to vomit almost continuously. At this

From the Communicable Disease Division, Herman Kiefer Hospital, Detroit, Michigan.

TABLE I.

Date of Lumbar Puncture	Polymorphonuclear Count in CSF	Gram Stain	Sugar mg. %	Total Protein mg. %	Blood Culture B. coli	Clinical State
4-19-46	620	No bacteria found	27	100	+	Irrational at times
4-20-46 a. m.	540	"	Below 10	90	+	Rational; stiff neck and back
4-20-46 p. m.	6,200	"	32	132	+	Severe backache
4-21-46	2,100	"	Below 10	97	+	Improved
4-22-46	52 50% lymphocytes	"	Below 10	95	+	Conjunctivitis worse
4-23-46	450	"	35	90	+	Purulent discharge from eye
4-24-46	50	"	39	108	0	Stiff neck; improved conjunctivitis; apathetic
5-3-46	4	"	88	21	0	Nauseated; edema of face

time the urine was normal. On April 30, sulfadiazine was discontinued. The sulfadiazine level was 42 mg. per cent; the blood nonprotein nitrogen was 33 mg. per cent.

During the next seven days treatment was directed toward allaying glomerulonephritis, which had developed during sulfadiazine administration. The urine, which had been normal, contained albumen, red blood cells, and casts. At no time were sulfadiazine crystals recovered microscopically. Three catheterized urine cultures remained sterile. For four days the patient had almost continuous emesis. She developed swelling of the hands and face. She became anuric on May 3. At this time the sulfadiazine level of the blood had fallen to 8 mg. per cent; the blood nonprotein nitrogen was 38 mg. per cent; the blood chlorides were 514 mg. per cent. The patient began voiding spontaneously on May 6, and from then on the course was uneventful except for persistent nausea which continued to May 12, when pyridoxine 25 mg. per cent was given intravenously with dramatic cessation of nausea and vomiting. The drug was repeated twice daily for three days. On May 19, the patient was discharged from hospital, recovered. She still complained of moderate stiffness of the back. No residual sequellae were present on dismissal nor were evident one year later.

The second patient demonstrated several features of interest:

1. Puerperal endometritis and septicemia resulting in B. coli meningitis.

2. Recovery from B. coli meningitis under penicillin therapy.

3. A glomerulonephritis either the result of E. coli infection or a toxic reaction to sulfadiazine.

4. Persistent vomiting which apparently responded to the intravenous use of pyridoxine.

Summary

B. coli meningitis in adults has not infrequently been reported in the literature following the puerperal state.[1,6] Two cases with a similar pathogenesis were treated at this hospital and one patient recovered. The recovered patient received penicillin, both intramuscularly and intrathecally. Upon report of E. coli in the spinal fluid sulfadiazine was administered but was discontinued early because of a kidney complication, possibly attributable to administration of this drug.

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NEW VACCINE TO BE TESTED

Wide-scale tests of a new vaccine that may stop a disease of both man and cattle and at the same time increase the quantity of milk for human consumption are getting under way in Michigan.

The vaccine, developed by Dr. I. Forest Huddleson, bacteriologist of Michigan State College, is for undulant fever.

Some 220,000000 pounds of milk are lost each year in Michigan alone because of the disease in dairy cows, it is estimated.

No harmful effects on breeding or milk production were caused by the vaccine in preliminary tests on cows. Almost half, 43 per cent of animals suspected of harboring undulant fever germs, were free of infection after being vaccinated.

The great value of the vaccine is expected to come through the possibility of preventing the spread of the disease in animals of recently infected herds. This will make it possible to eliminate infected animals, immunize the remainder and have not only a disease-free herd but one which is immune to further attack from the disease.

The Michigan State College laboratory is prepared to produce the vaccine in quantities to treat 2,000 cattle daily. Distribution within the state through registered veterinarians has been authorized by the Michigan Commission of Agriculture. None will be available outside Michigan until Dr. Huddleson and associates learn more about the vaccine's effectiveness, work out distribution problems and apply for a federal license.—*Science News Letter,* November 15, 1947.

Senile Cataract

From the Standpoint of the General Practitioner

By C. S. O'Brien, M.D.
Iowa City, Iowa



GRADUAL FAILURE of vision in older people is often the result of degenerative changes in the crystalline lens, i.e., cataract. Since advice ordinarily is sought first from the family physician, it is important that he know something of this common ocular disease.

Any opacity of the crystalline lens is known as cataract. The healthy lens is a small, biconvex, transparent structure situated immediately behind the pupil; it is somewhat like the lens in a camera and serves a similar purpose, i.e., to focus rays of light and form an image on the retina.

A cataract may be partial or complete. In the early stages of senile cataract the lens is only partially opaque and the vision moderately diminished, but eventually the cataractous changes occupy the entire lens and vision is reduced to the differentiation of light and darkness.

Incidence.—Senile cataract is exceedingly common, and many people beyond fifty years of age gradually lose vision as a result of this condition. It usually affects both eyes but commonly is more advanced on one side than on the other.

Etiology.—The exact cause is unknown but the lens opacities are believed to be due to metabolic changes associated with advancing age.

Pathology.—The lens is composed of long, thin, ribbon-like fibers laid one over the other in a manner similar to that of an onion. In the degenerative changes associated with cataract formation, the lens fibers separate, swell and degenerate into amorphous masses with resultant formation of opacities.

Presented at the eighty-second annual session of the Michigan State Medical Society, Grand Rapids, Michigan, September 25, 1947.

From the Department of Ophthalmology, College of Medicine, University of Iowa.

Diagnosis.—The diagnosis of cataract usually is not difficult but perhaps not so easy as some would believe. At times another ocular disease is present, and this may alter the prognosis.

Symptoms.—Gradual loss of vision is the usual complaint, the patient stating that objects appear hazy, foggy or cloudy. Sometimes stationary dark spots which do not change position with movements of the eye are described. Undue sensitivity to light exists in some patients. Others may complain of double or multiple vision in one eye. Also, objects may appear distorted. A few state the vision is better in dim light, as it is when most of the lens opacities are located in the central areas; others apparently have better vision in bright light, as is the case when the opacities are more dense in the peripheral parts of the lens. The ability to distinguish light and darkness is never lost with cataract; if light perception is absent, some disease of the retina or optic nerve coexists.

In certain instances, an elderly patient may boast of "second sight." This is always an indication of cataract, and eventually the entire vision will be lost, i.e, all except light perception. By "second sight" the individual means that, after wearing glasses for several years for reading, it is again possible to read, sew, et cetera, without glasses. But usually the patient does not volunteer the information that his distant vision is extremely poor. Advanced sclerosis or hardening of the lens nucleus is the usual cause for "second sight."

Congestion, redness or pain in the eye is never present with cataract.

Signs.—The pupil in a healthy eye appears black, but when a cataract is forming, gray or white areas appear in this region. In advanced cataract the entire pupil appears gray or white. An exception, in which the pupil always remains dark, is due to sclerosis of the lens nucleus and is known as brown or black cataract; however, this condition is not too common.

Diagnosis should never be made without an examination with the ophthalmoscope. With this instrument the opacities appear black against the orange-red reflex from the ocular fundus. If the cataract is in the early stages, the structures in the back of the eye may be seen but if the lens opacities are dense, even the orange-red reflex is lost. The fundus cannot be seen through a brown or black cataract.

Differential Diagnosis

Gradual loss of vision in older people occurs with other conditions as well as with cataract. These conditions must be differentiated since the prognosis and treatment are not the same. It must be remembered that any of these conditions may be present along with cataract.

Glaucoma.—The chronic non-congestive type of glaucoma, or so-called hardening of the eyeball, occurs in the same age group as cataract, causes gradual loss of vision and is not accompanied by redness, congestion or pain in the globe. Thus, in its symptoms, it is similar to cataract. However, the findings are entirely different in the two diseases, also the prognosis and treatment. In glaucoma the lens is transparent or at least not sufficiently opaque to account for the diminished vision; the intraocular pressure is elevated; the field of vision is abnormal; the head of the optic nerve is depressed and pale.

The differential diagnosis is important since lost vision in glaucoma cannot be restored and the patient should always have treatment once the diagnosis is made. Many physicians in general practice appear to be unfamiliar with glaucoma and seem to think cataract is almost the only cause for diminished vision in senility. If such is the case and an individual with glaucoma is told he has cataract and advised to wait until it is "ripe" before seeking treatment, he will probably go blind and remain so.

Senile Macular Degeneration.—Aged people with arteriosclerosis may have degenerative changes in the retina. These appear with the ophthalmoscope as irregular light and dark areas in the region of the macula.

Optic Atrophy.—Atrophy of the optic nerve, appearing with the ophthalmoscope as a pallor and slight cupping of the nerve head, is most often associated with tabes, general paresis, meningovascular syphilis or multiple sclerosis. Laboratory tests for syphilis may be of assistance in diagnosis.

Diabetes, Arteriosclerosis, Hypertensive Vascular Disease, Blood Dyscrasias.—Such diseases may cause hemorrhages and degenerative changes in the retina, and thus reduce vision. These changes may be visualized with the ophthalmoscope.

Prognosis

The outlook for restoration of vision in uncomplicated cataract is good. If other ocular pathologic conditions, such as those mentioned above, exist, removal of the lens may be of little or no benefit. Happily, most patients have only cataract, but only a thorough examination makes such a decision possible. Other pathologic states must be ruled out before a good prognosis can be offered.

Advice to the Patient.—The following is suggested:

Treatment: Drug therapy is of no avail. Restoration of vision is possible only by surgical removal of the cataract. The operation is made under local anesthesia and is not painful.

Time for Operation: An operation is not advisable if the patient still has useful vision in the better eye. If an operation is made at this time, the patient will see double after having been fitted with glasses; this is the result of an inequality in size of the two retinal images and the displacement of the image in the operated eye by prismatic action of the strong lens. It is therefore wise to advise the patient not to have an operation as long as vision is sufficient for the usual pursuits. In other words the operation may be made when the vision in the better eye is inadequate and the patient cannot follow his usual routine.

It was formerly believed advisable to wait until the cataract was "ripe" before removing the lens, but this is not necessary with modern methods of operation. It is unnecessary to keep any patient in comparative blindness for months or years awaiting the ripening of a cataract.

Needless to state, the time for operation varies in different patients. For example, a tailor or a mechanic will need an operation sooner than a common laborer, since the former need better vision to carry on their work.

In conclusion, it should be emphasized that vision can be restored only by removal of the cataractous lens.

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"No great deed is done by falterers who ask for certainty."—George Eliot.

Detroit Physiological Society

Session of October 16, 1947

The Effect of Asphyxia on Blood Clotting

Joseph L. Ponka. From the Division of General Surgery of the Henry Ford Hospital, Detroit, Michigan.

It is occasionally intimated by pathologists, in reporting autopsies, that a fluid state of the blood in a body is suggestive of oxygen deficiency at the time of death. Several manuals on postmortem examinations contain similar statements. An experimental study was undertaken to determine the effects of severe asphyxia on the clotting mechanism, as judged by *in vitro* tests.

Experiments were carried out on eleven healthy dogs. The animals were rendered unconscious with ether, after which a catheter with a distensible balloon was inserted into the trachea. Ether-oxygen anesthesia was continued through this closed system. Both femoral veins were exposed. A sample of blood was removed from the right vein and divided into three rubber-capped test tubes containing helium, thus avoiding any contact with oxygen. The clotting time (Lee and White method) of this sample was noted. The endotracheal catheter was then clamped for five minutes, or until the animal was almost dead of asphyxia. A second sample of blood was removed from the left vein, and its clotting time was determined. With two exceptions, the prompt administration of oxygen by artificial respiration with the anesthesia apparatus permitted the animals to recover, after which a sample of the re-oxygenated blood was obtained. The blood specimens removed before, during, and after the severe asphyxia showed no significant differences in clotting time.

Recent Work on Prothrombin and Thrombin

Arnold G. Ware and Walter H. Seegers. From the Department of Physiology, Wayne University College of Medicine, Detroit, Michigan.

The purification of prothrombin and thrombin has caused many difficulties during the past, but it is now possible to get regularly preparations which approximate purity. Preliminary studies of these preparations, with the aid of the ultracentrifuge, indicate that the thrombin molecule is much smaller than prothrombin. There is a possibility that thromboplastin activates prothrombin by cleavage of the prothrombin molecule.

Although thromboplastin is limited in its capacity to activate prothrombin, it is not used up in the reaction. The thromboplastin can be recovered and used over and over again. Another fundamental contribution is concerned with the discovery of a factor in plasma which accelerates the interaction of prothrombin and thromboplastin. This accelerator acts by speeding up the formation of thrombin but is apparently not absolutely necessary for the formation of thrombin. Quantitative methods for the determination of the accelerator concentration have been worked out, and it is believed that this accelerator has a very important bearing on the quantitative determination of prothrombin by one-stage methods.

The Concentration of Bile Salt of the Blood in Normal Individuals and Patients Suffering from Liver Disease

G. L. Walker, M. C. Hoffman and C. G. Johnston, Wayne University College of Medicine, Department of Surgery, Detroit, Michigan.

Using a method for the determination of total bile acids in blood by means of fluorimetric analyses, studies were made on a group of forty hospitalized patients with and without liver disease. Normal blood levels were determined in eighteen patients considered to be without liver disease, revealing an average bile acid concentration of 1.2 mgm. per cent and a range of 0.4 mgm. per cent to 1.8 mgm. per cent.

To these patients there was then administered orally a concentrate of ox bile in amounts up to 4 grams over a two-day period, the bile acid concentration amounting to 480 milligrams per gram of concentrate. The resultant daily blood levels demonstrated no significant elevation or decrease. Similar studies were conducted on twenty patients with various forms of liver disease which may be grouped into cirrhoses, common duct obstructions (including biliary tract disease), and acute hepatitis. The initial levels in the first two groups were variable, ranging from 1.6 mgm. per cent

(Continued on Page 71)

Know Your Legislators

There is a somewhat general misconception that legislators and politics are "untouchables," that those who take up politics as a life's work or who are forced into political positions by public demand are to be avoided, and that politics as a whole is a sordid mess that one should never contemplate without holding his nose.

So long as we live under a democratic form of government, which we have done rather successfully for nearly two centuries, legislators and politics will be necessary. Webster defines politics as "The science and art of government." It is something to be studied; not to be avoided. Legislators are people; most of them good people and upright citizens, "even as you and I." We should make them our friends.

It is impossible for one man to know everything, and each legislator must seek advice on the various bills that come before him. Who, if not the Doctor of Medicine, is in position to advise on legislation pertaining to problems of health? Know your legislators. Invite them to your County Medical Society meetings. Offer them your services. Help them in every way that you can, especially by giving sound advice on health problems, keeping constantly in mind that what is good for the public is good for our profession.

P. L. Sedwick

President, Michigan State Medical Association

President's



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Editorial

A SOCIALIZING PATTERN?

IS THERE a concerted action to socialize medicine? Or, may we, the doctors, be complacent because the National Compulsory Health Bills did not pass in the last session of Congress? Those who remember back a few years will never forget the unfavorable propaganda that appeared in the press and the magazines at the time Thurman Arnold was preparing for and did rake the American Medical Association over the coals and convicted them of breaking the Sherman Antitrust law.

Senator Vandenberg warned a group of Michigan State Medical Society and Michigan Medical Service officers, on October 30, 1947, that it would amaze us to know how easily Socialized Medicine could be accomplished in the United States. He said the proponents are working around the clock, in season and out, while the medical people oppose the theory only when Congress is in session and dangerous bills are pending. Fire cannot be put out unless we realize that we *have* a fire, and we are willing to fight with determination.

Is there a fire? If so, who is feeding it?

Harper's Magazine

Bernard DeVoto *(Harper's Magazine,* September, 1947) reports the Centennial Session of the American Medical Association. He writes a very readable story, on the humorous side, but carrying some measure of ridicule. He "devotes" over two pages to a quasi-humorous report on the opposition of the medical profession to the Wagner-Murray-Dingell Bill, and to every effort to "change the form of medical practice." Dr. Edward A. Parkes, formerly pediatrician-in-chief at the Johns Hopkins Hospital, "by temperament and background surely no revolutionist," is freely quoted criticizing "the behavior of organized medicine (which) is humiliating."

DeVoto comments on the Washington Health Group Association and the subsequent Supreme Court decision. He reports the sense of the American Medical Association that "there must be no federally controlled health program. There must be no federal control over the practice of medicine . . . all effective power must be reserved to organized medicine." He confuses the issue by involving preventive medicine in the National Health Programs, and implying opposition to that.

DeVoto also refers to the Taft Bill: "Those who determine the American Medical Association policies certainly know that the Taft Bill for a national health program is not meant to pass, or even to come to a vote." Support to that bill is said to be only "to confuse the issue." The whole tone of the article is that the medical profession is opposing all progressive measures in the distribution of medical care, and including preventive medicine. Does DeVoto use that most dangerous weapon, ridicule, to laugh socialized medicine onto the medical profession?

Look Magazine

Look Magazine for November 11, 1947, asks, "Can We Solve Our Health Problems?" in an article by Harold B. Clemenko. This you should see, as well as read. Two-thirds of the page is a picture of a group of people sitting supposedly in some clinic or doctor's office. They should not be in a clinic for those who cannot afford to pay, for they all look well dressed. One boy has braces and a crutch, and the caption reads, "These people want medical advice; three of four families like them need help to meet medical bills." The seventeen million draftees are mentioned. Figures are quoted: 23,000,000 Americans have a chronic disease or physical impairment, 7,000,000 are incapacitated by sickness or other disability in any given day; 40,000 lives could be saved from cancer by providing detection centers; one out of every seven young men is in *urgent* need of some kind of medical or dental treatment; 15,000,000 Americans living in 405 of all U. S. counties have no recognized hospitals. Half the women who die in childbirth and a third of the babies could be saved, if known measures were applied.

Then the questions are asked, "What is the reason for this condition? How can we remedy it? For President Truman's answer turn the page." The President says most Americans cannot afford adequate medical care. The perennial Wagner-

Murray-Dingell Bill is outlined, showing "complete" medical service which includes "family physician, specialist, surgeons, hospital care, x-rays, laboratory tests, eyeglasses, special appliances, unusually expensive medicines, limited dental and home nursing care." "In short, this law (Wagner-Murray-Dingell Bill) will eliminate your doctor bills for life."

Arguments are given for the program, prominent among them being "the doctor will benefit because the plan will eliminate the uncollected bills which now represent 25 per cent of his practice." The Truman-Wagner-Murray-Dingell measure is presented as the answer to all medical problems.

The arguments against the plan are weakly presented, dubbing the Taft Bill a plan "offering charity instead of insurance," and calling it "The Taft Charity Bill." Plainly, the author of this article has not read that bill, or if he has he deliberately misinterprets it. He claims the growth of voluntary plans is too slow, from 700,000 in 1942 to 5,000,000 in four years, or one million a year. But it might be sevenfold in four years, and that would rapidly cover the nation. "But health authorities (who are they but employes of some government bureau?) believe that although voluntary plans have been growing phenomenally, their rate of increase will now slow up as they are forced to seek new members in the low-income groups."

And the final blast: "The future health of America must be safeguarded. Will we do it with compulsory national health insurance?"

Parade

Parade, the Sunday picture magazine of the *Detroit Free Press* for November 16, 1947, joins in the "parade" with an article by Edward J. Nickel, "Programs for National Health." Again we look at the "facts," as he calls them, and they are not pretty. "One-third of the nation's young men were declared unfit for military service"; "One million deaths occur each year from chronic diseases alone"; "seventeen million Americans now living will die of cancer unless a cure is found." The merits of the two bills which will come up in Congress are given in two columns, side by side, and this is not too bad a presentation, except that it could be much more enthusiastic.

Is there a pattern discernible? Could some means have been found to stimulate all this propaganda, and make it as "Impartial" as possible by seeming to present both sides?

We reported recently that seventy-five millions of dollars have been used by federal bureaus for the spread of the socialized medicine plans, and that a mission is now in Japan attempting to foist a Wagner-Murray-Dingell Bill on helpless defeated Japan. On Tuesday, November 17, 1947, the *Chicago Tribune* reported editorially that the executive branches had admitted diverting fifty millions of dollars from the Greek relief as appropriated by Congress to the ballyhoo of the food plans of meatless Tuesdays and eggless and poultryless Thursdays. If money can be so used with impunity, these same or other executive branches can do the same thing to promote their socialistic philosophies. The Third Interim report of the Committee on Expenditeures says they *have.*

STILL A PATTERN?

TWO DOCTORS a few days ago called the editor's attention to an article in *Time* for December 1, 1947, reporting that Bernard M. Baruch has advocated compulsory health insurance, and called upon the doctors to stop their opposition to the Wagner-Murray-Dingell Bill. We read the article and asked several persons, not doctors, to read it and give their opinions. They all interpreted it the same, as favoring the national compulsory health program of Wagner-Murray-Dingell. The article reports that, "Elder Statesman Bernard M. Baruch is a doctor's son. In the past few years vigorous, health-minded Bernie Baruch has given millions for the advancement of medical education and research. Last week he talked like a Dutch uncle to a Manhattan gathering of 600 medicos and hospital administrators. *'It is high time,' he said, 'that doctors give up their stiff necked opposition to compulsory health insurance.'* "

Said Baruch: "[Voluntary health insurance] is not enough. . . . What troubles me most are the needs of that sizable segment of society which does not earn enough to pay for voluntary insurance. . . . Nothing has been suggested so far which promises success other than some form of insurance covering these people in by law and financed by the Government, at least in part. . . . A form of compulsory health insurance . . . can be devised . . . without the Government taking over medicine.

something I would fiercely oppose." (This is quoted word for word, deletions and all, exactly as it appeared in *Time,* December, 1947, page 49. Italics ours.)

"Said Baruch, staring defiantly at his silent audience: 'I do not fear Government taking its legitimate part in medicine, any more than I fear it in education and housing. . . . I urge the doctors to get in and pitch—not stand by on the sidelines.' Mr. Baruch said he was "shocked to learn that at least 4,000,000 men had been rejected as 4Fs."

Such was the report in *Time.*

The Truth?

Now what did Mr. Baruch say? The *New York Herald Tribune,* Sunday, November 23, 1947, said Mr. Baruch advocated a form of health insurance for low-income groups who are unable to pay for voluntary insurance such as the Blue Cross Plan offers. Mr. Baruch noted that in 1939 the American Medical Association estimated that two-thirds of the nation's population could not "afford the cost of serious illness." "Some of these can afford voluntary insurance, although inflation has reduced that number. But what of the little fellow? I have asked that of nearly every one with whom I have discussed medical care. Nothing has been suggested so far, which promises success, other than some form of insurance covering these people by law and financed by the government, at least in part, what some would call 'compulsory health insurance.' "

Mr. Baruch further said: "All law imposes compulsion. A form of compulsory health insurance for those who cannot afford to pay voluntary health insurance can be devised, adequately safeguarded, without involving what has been termed 'socialized medicine.' The needs can be met—as in other fields—without the government taking over medicine, *something I would fiercely oppose.* I do not fear government taking its legitimate part in medicine any more than I fear it in education or housing. *I oppose socializing here.* It leads ultimately to the police state, degradation of the individual and lessened well being."

Careful deletions can make a story sound different. "Comparing Mr. Baruch's statements regarding the persons who need medical assistance and cannot afford it, with health legislation now pending in Congress, Dr. Elliott (president of United Medical Services, before whose group Mr. Baruch was speaking) said, 'Mr. Baruch's ideas do not seem inconsistent with the Taft Bill, but are contrary to the Murray-Wagner Insurance Bill, which makes no provision for the medically indigent.' "

We hope some one will provide Mr. Baruch with Dr. Goin's analysis of the 4,000,000 rejected 4Fs; also a copy of the Taft Bill, and the Wagner-Murray-Dingell Bill, and see to it that he reads them. Many suggestions have been made that would provide for the person who cannot afford to pay for the costs of adequate medical care. The Medical Service plans are built on that basis, placing those costs on an insurance basis on the large group, who can in most instances pay this *budget plan.* To counter this insidious propaganda, every doctor should be completely familiar with the proposed bills; he must be on the alert for misleading statements whether in the press, magazines or by personal contacts. If allowed to go unchallenged, the propagandists will have gained their points.

BLUE CROSS LIBERALIZED

MICHIGAN HOSPITAL SERVICE has liberalized its payments to non-participating hospitals, including the Mercy Hospitals, by providing indemnity for hospital extras such as operating room, laboratory, most drugs, et cetera, up to $25.00 for patients in ward beds, and $32.50 for patients in semi-private rooms. This amount covers the average paid for such services during the past few years, according to the records. This gives an increased benefit estimated at better than 20 per cent for such patients.

Cases using more than the average in extras are still covered in participating hospitals, but if in non-participating hospitals they will now have to pay for extras only when it is in excess of the average as determined by the figures used in this liberalization of the benefits. Under the new plan, patients in non-participating hospitals will have much nearer complete care, but the advantages of participating hospitals is maintained—complete coverage. Certificate holders who must have care in non-participating hospitals, according to the enabling act under which Michigan Hospital Service operates, can be given care in non-participating hospitals only as "emergency." Where there are participating hospitals, they are supposed to be

used, but with the present shortage of beds, and the many parts of the state where half or more of the hospital beds are in Mercy Hospitals or other non-participating hospitals, the designation of "Emergency" has been obvious, but has been questioned by the Insurance Commissioner's office.

Blue Cross in Mercy Hospitals

Information has spread throughout the state that Blue Cross certificate holders could not go to Mercy Hospitals; that the services would not be paid. This never has been true. The rates paid in Mercy Hospitals, since they ceased to be participating, have been limited to the daily rate for room, board, and hall nursing care, the same as for all non-participating hospitals, but patients could go there and pay their own supplemental costs. These basic rates are now liberalized as mentioned above. This arrangement and eligibility to use non-participating hospitals does not seem to be understood by the doctors as it should be. We just heard of an unusually well-informed doctor who took his wife to a non-participating hospital and paid a rather large hospital bill, not even mentioning that he held a Michigan Hospital Service certificate which would have paid more than a hundred dollars of his account. Doctors should thoroughly understand this situation and be prepared to answer their inquiring patients' questions. These services are provided for the certificate holders, and they should understand what privileges they do have.

A committee representing the Michigan State Medical Society is at work with representatives of Michigan Hospital Service and advisors of the Mercy Sisters, trying to adjust the differences and misunderstandings between the Mercy Hospital Group, the Blue Cross, the enabling act and the office of the Commissioner of Insurance, all four of whom are involved. Many objections have been eliminated; many differences of understanding have been adjusted; the whole administration of Michigan Hospital Service has been changed, removing from consideration every personality who was in charge when the difficulties arose and the withdrawal of the Mercy Hospitals took place. Committee members believe much progress has been made, that so far as possible under the law every request of the hospitals has been granted, and the committee is hopeful for the future.

In the meantime, certificate holders who must use non-participating hospitals (including the Mercy Hospitals) are being better protected than ever before. This liberalization has been sought for a long time, and has just been approved by the Insurance Commissioner who is now willing to allow more services, being satisfied with the stability of the Michigan Hospital Service.

ON THE RUN . . .

The aged need more Vitamin B than the average adult because of their greater intake of carbohydrate.

. . .

In intractable duodenal ulcer, a high incidence of immediate relief follows either subtotal gastrectomy or vagus resection.

. . .

Vagal manipulation predisposes to respiratory complications.

. . .

In meningitis, more streptomycin is present in the cerebrospinal fluid after parenteral administration than in the non-meningitic.

. . .

In ascites associated with hepatitis, the sodium level in the blood serum usually falls, while that of the ascitic fluid is maintained.

. . .

The majority of small bowel tumors are malignant.

. . .

The risk of infection spread from the unburied dead is no greater than it is from the same group during life.

—Selected by W. S. Reveno, M.D.

DETROIT PHYSIOLOGICAL SOCIETY

(Continued from Page 66)

to 7.7 mgm. per cent, and the response to oral bile salt administration was likewise variable, ranging from elevations of 1.4 mgm. per cent to decreases of 1.3 mgm. per cent. Two cases of acute hepatitis were studied early in the disease and presented the highest normal levels obtained: 9.4 mgm. per cent and 5.2 mgm. per cent. Following bile salt administration, the level rose in the former to 16.4 mgm. per cent and in the other 10.4 mgm. per cent.

POSTGRADUATE COURSES

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Anatomy

February 12-May 27, (Thursdays)

Courses in Anatomy under the direction of Professor Russell T. Woodburne are offered to physicians wishing to review in this field. Such courses have been requested especially by surgeons and those preparing for specialty board examinations.

Course A will cover the Upper half of the body consisting of the head, neck, thorax and upper extremity.

Course B comprises the lower half of the body consisting of the abdomen, pelvis, and lower extremity.

The courses will run simultaneously. They will be given on Thursdays beginning February 12, at 1:00 P.M., and end May 27. The first part of the afternoon will be devoted to informal lectures, followed by practical studies in the Anatomical Laboratory. The evening hours to 10:00 o'clock will be devoted entirely to laboratory work.

Graduate or postgraduate credit may be arranged. Enrollment is limited. Fee—$30.00 for either course.

* * *

1948 Review Courses

Brief Review Courses for Returning Medical Officers and Civilian Physicians

INTERNAL MEDICINE	
Diseases of the Heart	April 5-9, inclusive
Metabolism and Endocrinology	April 19-23, inclusive
Diseases of the Blood	May 10-14, inclusive
Diseases of the Gastro-Intestinal Tract	May 17-24, inclusive
Allergy	May 24-28, inclusive
Recent Advances in Therapeutics	June 1-4, inclusive
Electrocardiographic Diagnosis	Aug. 30-Sept. 4, inclusive
OPHTHALMOLOGY	May 6-8, inclusive
OTOLARYNGOLOGY	May 3-5, inclusive
PEDIATRICS	April 14-16, inclusive
ROENTGENOLOGY DIAGNOSTIC	April 19-23, inclusive
SUMMER SESSION COURSES	
Anatomy, Bacteriology, Biochemistry	June 21-Aug. 13, inclusive

* * *

For further information address H. H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, 1313 E. Ann Street, Ann Arbor, Michigan.

Second Annual
Michigan Postgraduate Clinical Institute

Book-Cadillac Hotel, Detroit

March 10, 11, 12, 1948

Wednesday, March 10, 1948

Book-Cadillac Hotel, Detroit

A.M.

8:30 **REGISTRATION—Fifth Floor**

EXHIBITS OPEN—Fourth Floor

FIRST ASSEMBLY

Grand Ballroom

L. FERNALD FOSTER, M.D., Bay City, *Chairman*

8:55 **Welcome**

P. L. LEDWIDGE, M.D., Detroit
President, Michigan State Medical Society

C. L. CANDLER, M.D., Detroit
President, Wayne County Medical Society

9:00 **"The Management of Obstetrical Patients"**

HAROLD HENDERSON, M.D., Detroit
Associate Clinical Professor of Obstetrics and Gynecology, Wayne University College of Medicine

9:20 **"Differential Diagnosis of Tumors of the Chest"**

CAMERON HAIGHT, M.D., Ann Arbor
Associate Professor of Surgery, University of Michigan

9:40 **"Medical Diagnosis of Congenitally Anomalous Heart"**

SAUL ROSENZWEIG, M.D., Detroit
Senior Physician, Cardiology, Children's Hospital of Michigan, Assistant Professor of Clinical Medicine, Wayne University College of Medicine

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Pulmonary Edema"**

R. M. EATON, M.D., Grand Rapids
(Experimental Observations made in the Department of Surgery of Washington University School of Medicine, St. Louis, Missouri.)

11:20 **"Diagnosis and Management of the Slipped Epiphysis"**

A. G. GOETZ, M.D., Detroit
Associate Professor, Department of Orthopedic Surgery, Wayne University College of Medicine.

11:40 **"Useful Drugs in the Management of Allergic Diseases"**

J. M. SHELDON, M.D., Ann Arbor
Associate Professor of Internal Medicine, University of Michigan

P.M.

12:15 **LUNCHEON, Crystal Ballroom**

R. D. MCCLURE, M.D., Detroit, *Chairman*

1:15 **THE R. S. SYKES LECTURE:**
"The Diagnosis and Treatment of Breast Tumors"

F. A. COLLER, M.D., Ann Arbor
Professor of Surgery, University of Michigan



HAROLD HENDERSON



CAMERON HAIGHT



SAUL ROSENZWEIG



R. M. EATON



A. G. GOETZ



J. M. SHELDON



W. H. MEADE



W. S. REVENO

SECOND ASSEMBLY

Grand Ballroom

A. F. BLIESMER, M.D., St. Joseph, *Chairman*

P.M.

2:00 "Control of Intractable Pain"
W. H. MEADE, M.D., Lansing
Consulting Surgeon at St. Lawrence Hospital

2:20 "The Present Status of Anti-Thyroid Drugs"
W. S. REVENO, M.D., Detroit
Assistant Professor of Clinical Medicine, Wayne University College of Medicine; Physician, Harper Hospital

2:40 "Quantitative Serologic Tests: Their Use in the Diagnosis of Syphilis and Follow-up after Intensive Treatment"
L. W. SHAFFER, M.D., Detroit
Professor of Dermatology and Syphilology, Wayne University College of Medicine

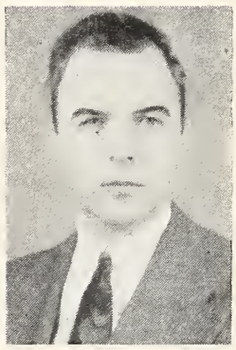
3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "The Treatment of Common Skin Diseases"
E. P. CAWLEY, M.D., Ann Arbor
Assistant Professor of Dermatology and Syphilology, University of Michigan

4:20 Clinical X-Ray Conference
Conducted by F. J. HODGES, M.D., Ann Arbor
Professor of Roentgenology, University of Michigan



F. J. HODGES



E. P. CAWLEY

THIRD ASSEMBLY

Grand Ballroom

E. D. SPALDING, M.D., Detroit, *Moderator*
Clinical Professor of Medicine, Wayne University College of Medicine

8:00 QUESTION BOX

D. H. KAUMP, M.D., Detroit
Pathologist at Providence Hospital; Assistant Professor of Pathology at Wayne University College of Medicine

H. J. VANDEN BERG, M.D., Grand Rapids
General Surgeon, Surgical Staff, Blodgett Memorial Hospital

M. F. OSTERLIN, M.D., Traverse City
Senior Instructor in Pediatrics, University of Michigan Medical School

W. F. SEELEY, M.D., Detroit
Professor of Obstetrics and Gynecology, Wayne University College of Medicine
Chief, Obstetrics and Gynecology, Harper, Receiving and Herman Kiefer Hospitals

10:30 SMOKER AND ENTERTAINMENT
Host: MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

(Admission by card furnished complimentary to all registrants)

Thursday, March 11, 1948

Book-Cadillac Hotel, Detroit

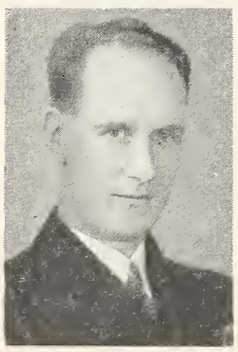
A.M.

8:30 REGISTRATION—Fifth Floor

EXHIBITS OPEN—Fourth Floor



H. J. VANDEN BERG



K. E. CORRIGAN

FOURTH ASSEMBLY

Grand Ballroom

C. G. CLIPPERT, M.D., Grayling, *Chairman*

9:00 "The Use of Atomic Energy in Medicine"
K. E. CORRIGAN, Ph.D., Detroit
Director of Research, Harper Hospital

9:20 **"The Present Trends in Treatment of Thrombophlebitis and Phlebothrombosis"**

R. W. Buxton, M.D., Ann Arbor
Assistant Professor of Surgery, University of Michigan Medical School

9:40 **"Endometriosis"**

R. L. Haas, M.D., Ann Arbor
Assistant Professor of Obstetrics and Gynecology, University of Michigan Medical School

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Pre-Anesthetic Medication"**

N. M. Bittrich, M.D., Detroit
Director Anesthesia, Providence Hospital, and Assistant Professor of Anesthesia, Wayne University College of Medicine

11:20 **"Management of Acute Conditions of the Abdomen"**

Matthew Peelen, M.D., Kalamazoo
Member, American Board of Surgery; Fellow, American College of Surgeons

11:40 **"Management of Acute Arthritic States"**

W. D. Robinson, M.D., Ann Arbor
Associate Professor of Medicine in charge, Rackham Arthritis Research Unit, University of Michigan

P.M.

12:15 **LUNCHEON, Crystal Ballroom**

H. A. Kemp, M.D., Detroit, *Chairman*

1:15 **"Medical Participation in Public Health"**

H. F. Vaughan, Dr. P. H., Ann Arbor
Dean, School of Public Health, University of Michigan



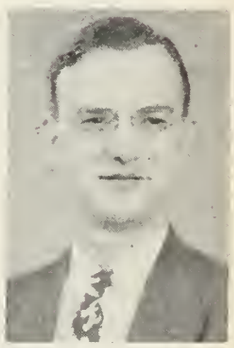
R. L. Haas



N. M. Bittrich



Matthew Peelen



W. D. Robinson

Thursday, March 11

FIFTH ASSEMBLY

Grand Ballroom

P.M.

E. I. Carr, M.D., Lansing *Chairman*

2:00 **"Psychosomatic Medicine"**

R. W. Waggoner, M.D., Ann Arbor
Director Neuropsychiatric Institute; Chairman of Department of Psychiatry, University of Michigan

2:20 **"Feeding Problems in Infancy and Childhood"**

Frank VanSchoick, M.D., Jackson
Fellow, American Academy of Pediatrics

2:40 **"Intestinal Obstruction"**

R. J. Noer, M.D., Detroit
Associate Professor of Surgery, Wayne University College of Medicine

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"The Acutely Red Eye"**

A. D. Ruedemann, M.D., Detroit
Professor of Ophthalmology, Wayne University College of Medicine

4:20 **CLINICAL PATHOLOGICAL CONFERENCE**
A Surgical Case

Conducted by O. A. Brines, M.D., Detroit
Professor of Pathology, Wayne University College of Medicine



R. W. Waggoner



R. J. Noer



O. A. Brines



C. R. Keyport

SIXTH ASSEMBLY

Grand Ballroom

G. C. Penberthy, M.D., Detroit, *Moderator*
Surgeon, Harper Hospital

P.M.

8:00 **PANEL DISCUSSION**

"First Aid to Acutely Injured Patients"

C. R. Keyport, M.D., Grayling,
Chief of Staff Emeritus, Grayling Mercy Hospital

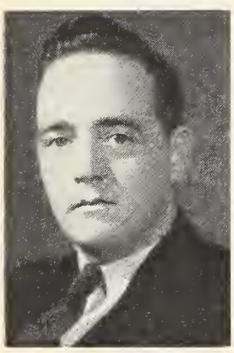
F. N. Smith, M.D., Grand Rapids
Consultant in Plastic Surgery

W. M. Tuttle, M.D., Detroit
Assistant Professor of Surgery, Wayne University College of Medicine

H. F. Falls, M.D., Ann Arbor
Associate Professor of Ophthalmology, University of Michigan

G. J. Curry, M.D., Flint
Chief, Section for Surgery of Trauma, Hurley Hospital

J. E. Webster, M.D., Detroit
Associate, Department of Surgery, Wayne University College of Medicine



W. M. Tuttle



J. E. Webster

Friday, March 12, 1948

Book-Cadillac Hotel, Detroit

A.M.

8:30 **REGISTRATION—Fifth Floor**

EXHIBITS OPEN—Fourth Floor

SEVENTH ASSEMBLY

Grand Ballroom

Merrill Wells, M.D., Grand Rapids, *Chairman*

9:00 **"Diagnosis and Treatment of Peptic Ulcer"**

R. K. Dixon, M.D., Detroit

9:20 **"Cancer of the Uterus"**

H. M. Nelson, M.D., Detroit
Chief Gynecologist, Woman's Hospital

9:40 **"Management of the Patient in the Menopause"**

H. H. Cummings, M.D., Ann Arbor
Chairman and Professor of Postgraduate Medicine, University of Michigan

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Vomiting in Infancy"**

H. A. Towsley, M.D., Ann Arbor
Associate Professor of Pediatrics, University of Michigan

11:20 **"Office Urology"**

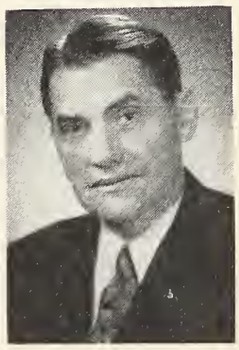
H. L. Morris, M.D., Detroit
Fellow, American College of Surgeons

11:40 **"Poliomyelitis"**

F. H. Top, M.D., Detroit
Director Herman Kiefer Hospital, Clinical Professor of Preventive Medicine and Public Health, Wayne University College of Medicine



R. K. Dixon



H. M. Nelson

Friday, March 12

P.M.

12:15 **LUNCHEON, Crystal Ballroom**
ARCH WALLS, M.D., Detroit, *Chairman*

1:15 **"Problems of the General Practitioner in the Small Town"**

J. S. DE TAR, M.D., Milan
Rural General Practitioner

"Problems of the General Practitioner in the Large City"

W. B. HARM, M.D., Detroit



H. L. MORRIS



F. H. TOP

EIGHTH ASSEMBLY

Grand Ballroom

W. S. JONES, M.D., Menominee, *Chairman*

P.M.

2:00 **CLINICAL PATHOLOGICAL CONFERENCE**
A Medical Case

Conducted by F. W. HARTMAN, M.D., Detroit
Pathologist, Henry Ford Hospital

2:40 **"Pneumonia and its Complications"**

L. G. CHRISTIAN, M.D., Lansing
Chief of Medicine, St. Lawrence Hospital

3:00 **INTERMISSION TO VIEW EXHIBITS**

3:40 **"The Recognition and Management of Tumors of the Lung"**

RICHARD H. MEADE, JR., M.D., Grand Rapids

4:00 **"Hypertension and its Management"**

F. A. WEISER, M.D., Detroit
Associate Professor of Clinical Medicine, Wayne University School of Medicine

4:20 **"Endocrinology in Gynecology"**

J. P. PRATT, M.D., Detroit
Chief, Department Gynecology and Obstetrics, Henry Ford Hospital

4:40 **"Office Treatment of the Nose and Accessory Sinuses"**

A. C. FURSTENBERG, M.D., Ann Arbor
Professor of Otolaryngology; Dean of Medical School, University of Michigan

END OF 1948 INSTITUTE



W. B. HARM



F. W. HARTMAN



L. G. CHRISTIAN



F. A. WEISER

After the Institute, Plan on Attending the
One-Day Conference on

"MODERN DIAGNOSIS AND TREATMENT OF VENEREAL DISEASES"

Saturday, March 13, 1948

HERMAN KIEFER HOSPITAL, DETROIT

(Program on Page 24)



J. P. PRATT

APPENDIX A

Proposed Amendments to the Constitution, MSMS

Presented to the MSMS House of Delegates on September 20, 1947

(These proposals will be presented to the MSMS House of Delegates in September, 1948, for final action)

ARTICLE I—NAME

Section 1. The name of the organization shall be the Michigan State Medical Society.

ARTICLE II—COMPONENTS

Section 1. This Society shall be made up of single County Medical Societies and Component County Medical Societies, now in affiliation with this Society or which may be hereafter organized and chartered by The Council of the Michigan Medical Society, provided that single County Medical Societies shall be a society of the physicians in one county; and provided further that Component County Societies shall be deemed to be an organization of the physicians of more than one county; and provided that when in the judgment of the House of Delegates it is deemed to be to the best interests of this Society, a charter may be granted to a society comprising the physicians of two or more counties. County Societies and Component County Societies hereafter in this Constitution and By-Laws will be called County Societies.

ARTICLE III—PURPOSE

Section 1. To bring into one organization the physicians of this State of Michigan, and through it and other state societies to form and maintain the American Medical Association.

Sec. 2. To maintain a program of educational service to the public on matters of health and hygiene.

Sec. 3. To encourage among members of the medical profession the interchange of views on all phases of medical advancement and to thus better equip each member of the profession to serve society and promote the public health.

Sec. 4. To maintain a program of scientific education for the members of the Society keyed to the constantly developing discoveries in the field of medicine; and to foster, encourage and co-ordinate postgraduate facilities for the medical profession as a whole.

Sec. 5. To disseminate advances in medical research among the profession generally by the issuance of scientific publications.

Sec. 6. To maintain and to advance the standards of medical practice in this state, both with respect to the highest concepts of ethics, and to the principles of scientific progress.

Sec. 7. To acquire and hold such real and personal property as may be necessary for the full and proper execution of the corporate purpose as detailed herein.

Sec. 8. To carry on such organization functions and activities as are deemed necessary to effectively accomplish the above purposes; provided, however, that the Socity shall engage in no activities that cannot be construed as relevant, incidental or necessary to its charitable, educational and scientific purposes.

ARTICLE IV—DIVISIONS

Section 1. This Society as a state unit of the American Medical Association, and as the state expression of the County Societies of Michigan shall have three major divisions.

1. The Society as a whole, as when it meets in general session.
2. The Scientific Assembly with its subordinate or related bodies.
3. The House of Delegates with its subordinate or related bodies.

ARTICLE V—MEMBERS

Section 1. This Society shall consist of active members, honorary members, associate members, retired members, members emeritus, and life members, elected in accordance with the By-Laws.

ARTICLE VI—THE SOCIETY AS A WHOLE

Section 1. The Society as a whole shall hold an annual meeting at such time and place and of such duration as the House of Delegates and The Council may determine. This power may be delegated to The Council by the House of Delegates.

ARTICLE VII—SCIENTIFIC ASSEMBLY

Section 1. The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine, its allied specialities and the problems of public health conservation.

ARTICLE VIII—HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Michigan State Medical Society and shall consist of Delegates elected by County Societies and Component County Societies.

ARTICLE IX—OFFICERS

Section 1. The officers of this Society shall be a President, a President-Elect, a Treasurer, a Secretary, an Editor, a Speaker and Vice Speaker of the House of Delegates, Councilors, Members of the House of Delegates of the American Medical Association, and Alternate Delegates to the House of Delegates of The American Medical Association.

ARTICLE X—THE COUNCIL

Section 1. The Council shall be the executive body of the Society. It shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and the House of Delegates between Annual Sessions.

Sec. 2. An Executive Committee of The Council shall consist of its Chairman, Vice Chairman, Chairman of the Finance Committee, Chairman of the County Societies' Committee, Chairman of Public Relations Committee, the President, the President-Elect, the Secretary and the Speaker of the House of Delegates.

ARTICLE XI—FUNDS AND EXPENSES

Section 1. Funds for meeting the expenses of the Society shall be raised by annual dues, special assessments and voluntary contributions.

Sec. 2. Annual membership dues and assessments shall be fixed by the House of Delegates.

ARTICLE XII—AMENDMENTS

Section 1. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published at least once during the year in The Journal of the Society, or sent officially to each County Society at least two months before the meeting at which final action is to be taken.

Sec. 2. This Constitution or any amendment thereto shall become effective immediately upon its adoption.

APPENDIX B

Proposed Amendments to the By-Laws, MSMS

Presented to the MSMS House of Delegates on September 23, 1947

(These proposals will be presented to the MSMS House of Delegates in September, 1948, for final action)

CHAPTER 1—MEMBERSHIP

Section 1. The charter of each County Society shall require that each of the provisions of the Constitution and By-Laws of this State Medical Society, together with each amendment to either thereof, hereafter adopted, in so far as the same is applicable, shall be an integral part of the Constitution and By-Laws of the County Society to which a charter is issued and shall in no way be inconsistent with the Constitution and By-Laws of the Michigan State Medical Society.

Sec. 2. The House of Delegates is empowered to revoke the charter of any County Society whenever it finds that such society has materially breached any of the provisions of the Constitution or By-Laws of the State Society or has failed to function within the expressed spirit and purpose of the State Society, to such extent that revocation of charter is compatible with the best interests of the State Society. Petition for the revocation of charter of any County Society may be filed with The Council by a Councilor of the district within which such society is located, or by any three members of the County or the State Society or by the President of the State Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such petition together with written notice of the time and place of hearing on the petition shall be served on the affected County Society not less than sixty (60) days before the date of such hearing. The affected County Society may within thirty (30) days after service upon it of copy of the petition file with The Council a written answer thereto. The Council shall afford the affected County Society a fair hearing of the matters complained of, a suitable opportunity to present its defense and to be represented by counsel. Written arguments may be filed on behalf of the affected County Society and on behalf of the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter. The Council shall make its decision based on the records, setting forth in writing its finding of facts, conclusions and reasons therefore. If two-thirds of The Council do not concur in the conclusion that the charter of the affected County Society shoud be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of The Council concur in the conclusion that the charter of the affected County Society should be revoked, the Chairman of The Council shall transmit to the House of Delegates a report, consisting of the decision of The Council with records annexed, and shall serve a copy thereof on the affected County Society. The House of Delegates shall at the next regular or special session thereof following the transmittal of such report, but not less than sixty (60) days thereafter, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to The Council for further hearing and report. The action of the House of Delegates on the report of The Council shall be the final decision with reference to the revocation of the charter of a County Society.

Sec. 3. Each member of a County Society who is not in arrears as to dues and assessments shall be privileged to attend each meeting and take part in all the proceedings and shall be eligible to any office within the gift of the Society except as otherwise provided.

Any member in arrears for dues in the amount for one year or more may regain membership either by paying up all back dues or by being again elected to membership, at the option of The County Society.

For the purpose of determining the dues for new members only, the fiscal year of the Michigan State Medical Society shall be divided into four three-month periods. New members shall pay adjusted annual dues and assessments for the unexpired quarterly periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the State Secretary and such benefits shall not cover any period prior to their becoming members in good standing.

Sec. 4. In addition to the qualifications specified in their respective Constitutions and By-Laws, County Societies shall exact as qualifications for membership and its continued tenure, the acceptance and adherence to the Principles of Medical Ethics of the American Medical Association in accordance with the interpretation thereof by the Judicial Council of the American Medical Association, and such other qualifications as may be provided by this Constitution and By-Laws.

Sec. 5. No member who is under sentence of suspension or expulsion from any County Society of this Society, or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Society.

Sec. 6. Transfer of membership from one County Society to another shall be effectuated in the following manner:

The member who wishes such transfer shall make application to the County Society which he wishes to join, stating his reason for desiring a transfer of membership, which must include the fact that either his residence or office location is in the jurisdictional territory of that society, and tendering payment of dues for the remainder of the current year, calculated to the nearest quarter.

The Secretary of the County Society to which application is made shall request certification of standing from the County Society in which membership is then held. Upon receiving such request, the Secretary of the latter society shall supply certification of good standing, provided the following requirements have been met:

1. All County Society dues and assessments have been paid for the calendar year in which application for transfer was made.
2. County Society dues shall have been paid to cover that portion of the year preceding application for transfer, the time being calculated to the nearest quarter.
3. A member being granted a transfer shall not be under suspension or facing charges of unethical conduct.
4. In case the County Society dues have been paid in full for the year, and certification of good standing is being issued, the Secretary of the County Society shall refund County Society dues represented by the unexpired portion of the year, calculated to the nearest quarter.
5. Upon receipt of certification of good standing, and favorable action by the County Society to which application has been made, the transfer of membership requested shall be in effect.

Sec. 7. Resignation for transfer of membership to another state society shall be effected in the following manner:

Any member in good standing, not facing charges of unethical conduct, whose State and County Society dues and assessments are not in arrears, and who has moved his home or office to another state, may tender his resignation, which shall be effective at the beginning of the next quarter. Such resignation shall be transmitted to the State Secretary, who shall give the departing member certification of good standing.

Provided the portion of the calendar year following such resignation is not less than one-quarter, the Secretaries of the State and County Societies shall refund any dues and assessments already paid for the remainder of the year, calculated to the nearest quarter.

Sec. 8. Only active members are eligible to Retired, Emeritus or Life Membership. Transfers shall be by election in the House of Delegates. Requests for transfer shall be accompanied by certification by the Secretary of the State Society, as to years of practice and years of membership in good standing. The County Society of such members shall make request for certification, in writing, to the Secretary of the State Society thirty days in advance of an Annual Session.

CHAPTER 2—MEMBERS

Section 1. *Active Members*—Active Members shall comprise all the active members of County Societies. To be eligible for active membership in any County Society, each person must be under license to practice medicine, surgery and midwifery by authority of the Michigan State Board of Registration in Medicine.

Sec. 2. *Honorary Members*—County Societies may elect as Honorary Members any persons distinguished for their services or attainments in medicine or the allied sciences, or other services of unusual value to organized medicine or the medical profession. Upon recommendation of a County Society, the House of Delegates may elect such persons as Honorary Members of the State Society. Honorary Members shall pay no dues to the State Society and shall be without right to vote or hold office in either County or State Society.

Sec. 3 *Associate Member*—County Societies may elect as Associate Member:

1. Any person not a member of the profession but engaged in scientific or professional pursuits whose principles and ethics are consonant with those of this Society.
2. An intern serving the first year in any approved hospital, an intern of longer standing, a resident physician in training, a teaching fellow not engaged in private practice, but not after five years from the receipt of first medical degree (M.D. or M.B.).
3. A commissioned medical officer of the United States Army, Navy, Public Health Service and Veterans Administration on duty in this state who is not engaged in private practice of medicine.
4. A physician not engaging in any phase of medical practice.
5. A physician, resident of the State of Michigan, for the period of time he is in active military service of the United States previous to his engaging in active practice.
6. An active member, by transfer, for the period of time he is temporarily out of active practice on account of protracted illness.

Upon recommendation of a County Society, the House of Delegates may elect such person as Associate Member of the State Society. An Associate Member shall not pay dues in the State Society, nor shall he have the right to vote or hold office in either County or State Society.

County Societies may require an Associate Member to pay certain local dues, out of which THE JOURNAL subscription is to be paid to the State Society and for which such Associate Member shall receive THE JOURNAL.

Sec. 4. *Retired Member*—A member who has maintained his membership in a County Society of the State Society for a period of ten or more years, and who is certified by the County Society as having retired from practice, may be transferred to the retired members' roster. He shall be entitled to receive the publication of the Society at such rates as The Council may, from time to time, determine. He shall not have the right to vote or to hold office.

Sec. 5. *Member Emeritus*—Any physician who has been in practice for fifty years, and who has maintained a membership in good standing for twenty-five years, may, upon application and recommendation of his County Society, become a Member Emeritus. A Member Emeritus shall be relieved from paying State Society dues. He shall be entitled to all the benefits and privileges of membership.

Sec. 6. *Non-Resident Member*—County Societies may elect and retain as a Non-Resident Member any physician residing and practicing outside of the county who is a member in good standing of his own County Society. A Non-Resident Member shall not have the right to vote or hold office.

Sec. 7. *Life Member*—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

CHAPTER 3—GENERAL MEETING

Section 1. During each Annual Session the Society shall hold one or more General Meetings. The number and time of these General Meetings to be determined by The Council with or without the recommendation of the House of Delegates. Each General Meeting shall be presided over by the President or in his absence by the President-Elect or the Chairman of The Council. This meeting shall be called "Officers' Night."

Sec. 2. The following shall be the order of business in the General Meeting at which the reports of the House of Delegates are received:

1. Call to Order
2. Announcements and reports of House of Delegates
3. Retired President's annual address
4. Induction into office of Incoming President
5. Introduced of newly elected officers
6. Special addresses
7. Resolutions and motions

Sec. 3. Each registered Member at an Annual Session shall have an equal right to participate in the deliberations of a General Session and each Active Member, Member Emeritus and Life Member so registered shall have the right to vote on pending questions before the General Meeting.

Sec. 4. The General Meeting or any section of the Scientific Assembly may recommend to the House of Delegates or to The Council the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and the public. Such investigations and reports shall not become official action or expression of the Society until approved by the House of Delegates or The Council.

CHAPTER 4—HOUSE OF DELEGATES

Section 1. *Composition*—The House of Delegates shall be composed of delegates elected by the County Societies. Each County Society shall be entitled to send to the House of Delegates each year one Delegate for each fifty members and one delegate for each additional major fraction thereof. Any County which holds a charter from this Society and has less than fifty members shall be entitled to send one Delegate if its annual report has been properly filed with the Secretary.

Sec. 2. Officers of this medical Society and members of The Council shall be ex-officio members of the House of Delegates, and, with the exception of the Speaker of the House of Delegates, shall be without power to vote in the House of Delegates. The Past-President shall be a member at large of the House of Delegates during the first year of Past-Presidency with right to vote and hold office. All Past-Presidents shall have the right to the floor in the House of Delegates accorded to a regular Delegate without the right to vote.

Sec. 3. The House of Delegates shall transact all of the business of the Society not otherwise specifically provided for; it shall adopt rules and regulations for its own government and for the administration of the affairs of the Society; it shall provide for the organization of Councilor Districts, and, it shall provide for a division of the work of the Scientific Assembly of the Society into appropriate sections, adding new or discontinuing old sections.

Sec. 4. The House of Delegates shall meet annually at the time and place of the meeting of the Society as a whole in General Session, and may hold such number of meetings as the House may determine or its business require, adjourning from day to day as may be necessary to complete its business and specifying its own time for the holding of its meetings.

Sec. 5. A Delegate must have been a qualified Member of the State Society for at least two years preceding election or a Member Emeritus of the Society for at least two years preceding election.

Sec. 6. A Delegate once seated shall remain a Delegate through the entire session and his place shall not be taken by any other Delegate or Alternate, provided that in case of emergency the House of Delegates may seat a duly accredited Alternate from his County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by an accredited Alternate next on the list as certified by the Secretary of the County Society involved.

Sec. 7. The officers of County Societies shall certify to the State Secretary the names of the Delegates and Alternates who shall represent them at any Annual or Special Meeting.

Sec. 8. A quorum of the House of Delegates shall be constituted from 40 per cent of the accredited Delegates, providing that a majority of such quorum shall not come from any one County Society.

Sec. 9. The Officers of the House of Delegates shall be a Speaker and Vice Speaker. The Secretary of the State Society, elected by The Council, shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Meeting. The Speaker of the House of Delegates shall be a member of The Council and of its Executive Committee with right to vote.

Sec. 10. (a) The House of Delegates is the legislative body of the Society, and shall have authority to adopt and institute such methods and measures as it may deem most sufficient for the upbuilding and establishing of the interest of the profession in Michigan.

(b) It shall concern itself and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws and public health.

(c) It shall be active in the education of the public in regard to medical research and scientific medicine.

(d) Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the regulations of that parent organization and as hereinafter provided.

The number of Alternate Delegates shall equal the number of Delegates to the American Medical Association. Delegates and Alternates shall hold office for two years.

At each annual election, candidates for Delegates and Alternates shall be nominated in number equal to or greater than the number to be elected. Election shall be by ballot. The required number of high candidates shall be declared elected.

In case of a tie vote between any number of high candidates the winner, or winners, shall be decided by drawing lots supervised by the Speaker of the House of Delegates, provided, however, that any candidate thus tied shall have the right to a decision by ballot if he requests same.

The number of Alternate Delegates shall equal the number of Delegates. They shall be elected in exactly the same manner after all Delegates have been elected.

Alternate Delegates shall have relative seniority according to the respective number of votes received by them, and such seniority shall be designated at the time of election. Alternate Delegates serving their second year shall hold seniority over those Alternate Delegates serving their first year in office; provided, however, that re-election as Alternate Delegate shall carry with it no additional seniority.

Any vacancies caused by failure or inability of Delegates to attend shall be assigned to Alternate Delegates in order of their seniority as defined in this section.

(e) It shall divide the state into Councilor Districts.

(f) It shall have the authority to appoint committees, standing or special, from among its members or the members of the Society. Such committees are to report to the House of Delegates and their members may participate in the debate upon their committees' report.

(g) It shall approve each memorial and resolution in the name of the Society before the same shall become effective. Provided, that in the interim, in the presence of necessity for prompt action The Council is empowered to act in behalf of the Society.

(h) It shall elect the Councilors upon the nomination of the Delegates of the Councilor District whose Councilor's term expires.

(i) The House of Delegates shall provide for the division of the scientific work of the Society into appropriate sections. It shall prescribe the rules governing the meetings of these sections and the election of officers.

(j) It shall present a summary of its proceedings at a General Meeting of the Society and publish its minutes in The Journal.

(k) It shall have the following reference committees appointed by the Speaker: Committees on—

1. Council Reports.
2. Officer Reports.
3. Reports of Standing Committees.
4. Resolutions.
5. Reports of Special Committees.
6. Miscellaneous Reports.

(l) No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

(m) The election of officers shall be held at the last meeting of the House of Delegates at the Annual Session. Each nomination shall be made from the floor of the House. The Speaker having declared the nominations for any office closed, shall appoint tellers. In the event of having only one nominee, the candidate may be elected by a *viva voce* vote. Members elected to office shall take office with the induction of the Incoming President.

(n) Each resolution introduced into the House shall be in triplicate and presented to the Secretary immediately after the Delegate has read the same and shall be referred to the proper reference committee by the Speaker before action thereon is taken.

(o) Robert's Rules of Order when not in conflict with this Constitution and By-Laws shall govern the parliamentary proceedings of the House of Delegates.

CHAPTER 5—OFFICERS

Section 1. Officers shall be installed at the General Meeting at which the reports of the House of Delegates are received. They shall serve until the next Annual Session, provided that Councilors shall serve for five Annual Sessions, and provided further that not more than four Councilor terms expire normally at any Annual Session; provided further that Delegates to the American Medical Association may serve for two Annual Sessions.

Sec. 2. Officers shall serve until their successors are elected and inducted into office.

Sec. 3. At the Annual Session of this Society, next following his election, the President-Elect shall be installed into and assume the office of the President immediately following the annual address of the Retiring

President. He shall serve until his successor takes office. The assumption of office shall occur in General Session of the Society as a whole at which the reports of the House of Delegates are received. If no General Meeting is held at the Annual Session, the induction into office of the Incoming President and the newly elected officers shall be in the last meeting of the Annual Session of the House of Delegates.

Sec. 4. The President shall preside at each General Meeting of the Society, and shall fill each vacancy in office and committee with the advice of The Council unless otherwise provided for; he shall appoint the members of each committee not otherwise provided for; he shall deliver the President's Address; he shall have a voice in the deliberations of the House of Delegates and he shall be an ex-officio member of The Council with right to vote.

Sec. 5. The President-Elect shall be a member of The Council ex-officio, and shall act for the President in his absence or disability. If the office of President shall become vacant, the President-Elect shall succeed to the Presidency. If the office of President shall again become vacant, the Council shall elect a President for the unexpired term.

Section. 6. The Treasurer shall be the custodian of all the invested funds and the securities of the Society. He shall be elected by The Council and be accountable through The Council to the Society. The Council shall cause an annual audit to be made of his accounts.

Sec. 7. The Secretary shall be an active member of the Michigan State Medical Society and shall be paid a salary to be determined by the Council. He shall be the recording officer of the House of Delegates, The Council, Scientific Assembly, and General Session. He shall also discharge the following duties:

1. Collect all annual membership dues and such other moneys as may be due to the Society; keep membership records and issue membership certificates.

2. He shall make all required reports to the American Medical Association.

3. He shall deposit all funds received in an approved depository and disburse upon order of The Council. The Council shall cause an annual audit of his accounts by a certified public accountant. He shall render a report to The Council reviewing the Society's activities and imparting recommendations for the advancement of the Society's interest at each meeting of The Council.

4. Under the direction of The Council and with the advice of the Editor, he shall be the business manager of THE JOURNAL.

5. He shall superintend all arrangements for the holding of each meeting in compliance with the Constitution and By-Laws and instruction of The Council.

6. He shall send out all official notices of meetings, committee appointments, certificates of election to office and special duties of committees.

7. He shall receive and transmit to the House of Delegates and to The Council each committee and officers' annual report.

8. He shall institute and correlate each new activity under the supervision of The Council, and shall work on County Society integration and furnish information to the public concerning health matters as directed by the President and The Council.

The Executive Secretary, not necessarily a physician or a member of the Michigan State Medical Society, shall be appointed by The Council annually and shall be remunerated by a salary which shall be fixed by The Council.

The Secretary shall, with the approval of The Council, assign to the Executive Secretary such of the above duties as he deems advisable.

Sec. 8. The Speaker shall preside at sessions of the House of Delegates. He shall, with the approval of the President, appoint all committees created by the House of Delegates, unless otherwise provided, and shall perform such duties as custom and parliamentary usage require. He shall have a right to vote only when his vote shall be the deciding vote. He shall be a member of The Council and of its Executive Committee with the power to vote.

Sec. 9. The Vice Speaker shall assume the Speaker's duties in the Speaker's absence and shall have the right to vote when assuming such duties.

CHAPTER 6—THE COUNCIL

Section 1. The Council is the Executive body of the Society. It shall determine its own time and place of meeting. It shall elect its own Chairman and Vice Chairman to serve one year. It shall elect to serve one year, its Chairman, Vice Chairman, Chairman of the Finance Committee, Chairman of the County Societies' Committee, and Chairman of the Publication Committee; these with the President, the President-Elect, the Secretary, and the Speaker of the House of Delegates shall constitute the Executive Committee of The Council.

Sec. 2. Each Councilor shall be the organizer, peacemaker and censor for his District. He shall visit each County Society in his District at least twice a year and keep in touch with the activities of the societies constituting his District. He shall make such reports as the Chairman of the Council shall request concerning the condition of the profession in that District.

Sec. 3. Upon written complaint of at least half of the Delegates of the Councilor District involved, presented to the House of Delegates, in regular or special session, stating that the Councilor of said District has been remiss in his duties as prescribed above, and has been notified a month previously of this proposed action, the Speaker of the House shall bring the matter before the meeting for consideration. On two-thirds' vote of the House of Delegates this office shall be declared vacant and a successor elected.

Sec. 4. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by his County Society, may appeal therefrom to The Council of the Michigan State Medical Society. Notice of appeal shall be in writing and set forth the specific reasons for such appeal. The notice shall be filed with said Council and a copy thereof served on the member's County Society. Unless such appeal is taken within thirty (30) days after service by registered mail, return receipt requested, of the copy of the order of discipline on the affected member, such order shall be final and effective. As soon as practicable after receiving copy of notice of appeal, the County Society shall forward to The Council a complete record of the case, which record shall consist of the petition, answer, testimony, order appealed from and all other pertinent writings and exhibits. The Council shall thereupon transmit such record together with the notice of appeal to the Committee on Ethics of the State Society for review. The Committee on Ethics shall promptly review the record and may request the County Society or the affected member to furnish such further proofs in writing as the Committee deems necessary for the proper and full review of the matter. Written arguments may be filed by the County Society and the affected member within such time as may be designated by the Committee on Ethics. The Committee on Ethics shall make its findings and recommendations in writing and report the same to the Council. The Council shall thereupon affirm, reverse or modify the order appealed from by written decision, a copy whereof shall be served on the County Society and the affected member. Unless, within sixty (60) days of the service upon him by registered mail of copy of such decision, the affected member takes an appeal to the Judicial Council of the American Medical Association, the decision of the Judicial Council shall be final and effective. Provided further that the County Society, aggrieved by the decision of The Council of the State Medical Society, may within sixty (60) days appeal to the Judicial Council of the American Medical Association.

Sec. 5. It shall make careful inquiry into the condition of the profession in each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such County Society as already exists and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians in the same locality and shall continue these efforts until every reputable physician of the state has been brought under the Society's influence.

Sec. 6. It shall upon application provide and issue charters to County Societies organized in conformity with this Constitution and By-Laws and revoke such charters when deemed necessary.

Sec. 7. The Council shall direct and control the publication of THE JOURNAL.

Sec. 8. The Council shall elect a Secretary, an Editor of THE JOURNAL and a Treasurer at its annual meeting in January of each year. They shall take office immediately and serve for a term of one year, or until their successor is elected and takes office.

Sec. 9. The funds of the Society shall be disbursed only by order or action of the Council.

Sec. 10. Invested funds of the Society shall be delivered to the custody of the Treasurer by the Secretary.

Sec. 11. The Secretary shall collect annual dues, assessments and moneys owing the Society, placing them in a depository approved by The Council. He shall disburse them only upon order of The Council. The Council shall cause an annual audit be made of the funds of the Society by a certified public accountant and shall require the Treasurer and Secretary to give a bond in an adequate amount, this bond to be paid for from the funds of the Society.

Sec. 12. The Chairman of the Council, subject to its approval, shall appoint an Auditing Committee of three members, designating one of the members as its chairman.

The Auditing Committee shall inspect all bills and claims against the Society, and no bill or claim shall be paid except upon voucher or draft having the approval of at least two of the three members of the Auditing Committee. Provided, however, that any bill or claim may be paid without the approval of any member of the Auditing Committee by a majority vote or written approval of a majority of all the members of the Executive Committtee.

Sec. 13. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

Sec. 14. The Council shall render an Annual Report to the House of Delegates.

Sec. 15. The following County Societies shall constitute the Councilor Districts of the state:

First District—Wayne.

Second District—Eaton, Hillsdale, Ingham, Jackson.

Third District—Branch, Calhoun, St. Joseph.

Fourth District—Allegan, Berrien, Cass, Kalamazoo, Van Buren.

Fifth District—Barry, Ionia-Montcalm, Kent, Ottawa.

Sixth District—Clinton, Genesee, Shiawassee.

Seventh District—Huron, Sanilac, Lapeer, St. Clair.

Eighth District—Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola.

Ninth District—Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (including Antrim, Charlevoix, Cheboygan and Emmet), Wexford (Missaukee, Wexford).

Tenth District—Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Gladwin, Kalkaska and Ogemaw combined).

Eleventh District—Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana.

Twelfth District—Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger.

Thirteenth District—Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon.

Fourteenth District—Lenawee, Livingston, Monroe, Washtenaw.

Fifteenth District—Macomb, Oakland.

Sixteenth District—Wayne.

CHAPTER 7—STANDING COMMITTEES

Section 1. The following standing committees shall be appointed by the President with the advice of The Council:

(a) Committee on Legislation.
(b) Committee on the Distribution of Medical Care.
(c) Joint Committee on Health Education.
(d) Medical Legal Committee.
(e) Committee on Preventive Medicine.
(f) Committee on Postgraduate Medical Education.
(g) Committee on Public Relations.
(h) Committee on Ethics.

Sec. 2. The Committee on Legislation shall consist of a Chairman, the President-Elect of the State Medical Society and the Chairman of The Council of the State Medical Society and members to be appointed by the President with the advice of The Council.

The Committee on Legislation shall utilize every organized influence of the profession for the promoting of such legislation as will be for the best interests of the public's health and that of scientific medicine. It shall work under the direction of the House of Delegates or of The Council when the House of Delegates is not in session. No bill or proposed law or amendment shall be delivered to any member of the Michigan State Legislature for introduction in the name of this Society or by any of its committees until such proposed legislation shall have been endorsed and approved by The Council.

It shall submit an annual report with recommendations to the House of Delegates.

Sec. 3. The Committee on the Distribution of Medical Care shall consist of five members appointed by the President with the advice of The Council.

This Committee shall collect, analyze and distribute information, and advise Medical and other groups or individuals concerning Medical Economic Problems in Michigan. It may appoint sub-committees and seek information and co-operation whenever such action, in its judgment, is necessary to public welfare. It shall act as a central clearing house for the activities of Committees on the Distribution of Medical Care of the various County Societies throughout the state.

Sec. 4. The Medical Legal Committee shall consist of five members appointed by the President with the advice of The Council.

The Committee shall co-operate with the Medical Legal Counsel of each County Society in advising members as to their rights and duties in the practice of their profession.

It shall furnish upon application by any official Medical Legal Counsel of a County Society or a Councilor information and advice pertaining to the rights and duties of physicians in the practice of their profession.

Sec. 5. The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the advice of The Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944 the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term.

Sec. 6. Committee on Preventive Medicine shall consist of the Chairmen of the following Committees:

Committee on Cancer Control,
Committee on Maternal Health,
Committee on Venereal Disease Control,
Committee on Tuberculosis Control,
Committee on Industrial Health,
Committee on Mental Hygiéne,
Committee on Child Welfare,

Committee on Heart and Degenerative Diseases,
Committee on Radio,
Committee on Postgraduate Medical Education,
Representatives to the Joint Committee on Health Education,
Such other committees as may from time to time be appointed to study and develop programs dealing with specific diseases,
The State Health Commissioner.

The Chairman of the Preventive Medicine Committee shall be appointed by the President, together with the members of all special committees, with the advice of The Council.

The duty of this committee shall be to collect, analyze and distribute information on preventive medicine, and to advise medical and other groups or individuals concerning problems in preventive medicine and public health.

Sec. 7. The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the advice of The Council. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term.

The duty of this Committee shall be to supervise for the Michigan State Medical Society all present postgraduate medical training in the state and, with the approval of the Executive Committee of The Council, make any changes, additions or discontinuances of present programs and initiate such new programs as they deem advisable.

Sec. 8. The Committee on Public Relations shall be appointed by the President with the advice of The Council. It shall be the duty of this committee: (a) to integrate and publicize all approved plans and projects emanating from The Council, the Executive Committee, and other standing and special committees of the Michigan State Medical Society; (b) to consider all plans and projects, and make suggestions and recommendations for improving or changing such plans for integration and publicizing; (c) to develop further plans for better physician-public contacts.

Sec. 9. The Committee on Ethics shall consist of eight members appointed by the President with the advice of The Council, each member to serve for a four-year term, so staggered that two members are selected annually. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term.

The Committee shall render advisory opinions on questions of ethics submitted to it by The Council.

On request of The Council it shall conduct an investigation, under rules approved by The Council, concerning the ethical conduct of a designated member of this Society and report its findings to The Council.

CHAPTER 8—REFERENDUM

Section 1. At any General or Special Meeting of the Society as a whole in General Session, it may by a two-thirds vote order a general referendum upon any question pertinent to the purposes and objects of the Michigan State Medical Society, organized medicine or the health of the public, provided, however, that a quorum at such General or Special Meeting shall consist of 300 members of the Michigan State Medical Society who are in good standing.

Sec. 2. The House of Delegates, by a majority vote of its members, may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, provided 300 members of the Society, in good standing, are present to constitute a quorum; provided further that two-thirds majority of the members present at such meeting shall determine the question and make it binding.

CHAPTER 9—SEAL

Section 1. The Society shall have a common seal. The power to change or renew the seal shall rest with The Council.

CHAPTER 10—EMERGENCY

Section 1. When prompt speech and action are imperative, authority to speak and act in the name of the Society is invested in The Council with the consent of the President.

CHAPTER 11—ANNUAL DUES

Section 1. The Secretary of each County Society shall collect and forward the dues to the State Secretary on or before April first of each year.

Sec. 2. Any member in arrears after April first of each official year shall stand suspended until his name is properly recorded and his dues for the current year properly remitted.

Sec. 3. Any County Society which fails to make the reports required at least thirty days before the Annual Meeting of the State Society shall be held suspended and none of its members or Delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

Sec. 4. An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately following such duty.

CHAPTER 12—COUNTY SOCIETIES

Section 1. All County Societies now in affiliation with the State Society or those which may hereafter be originated in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws or with the Principles of Medical Ethics of the American Medical Association, will upon application to The Council receive a charter and become a component part of this Society.

Sec. 2. Only one County Society shall be chartered in any county.

Sec. 3. Each County Society shall be the judge of the qualifications of its own members; but, as such societies are the only portals to this Society and the American Medical Association, each reputable practitioner of medicine who meets the requirements specified in the By-Laws, Chapter 2, Section 1, shall be eligible to active membership.

(a) A County Society may expel, suspend or otherwise discipline any of its members in accordance with the provisions of its constitution and by-laws; provided, however, that any member against whom such action is taken shall be accorded the benefit of the following procedures:

(b) Efforts at conciliation and adjustment of differences shall precede formal complaint against a member sought to be disciplined.

(c) Complaints against a member must be in writing and referred to the Ethics Committee of the County Society and shall set forth with reasonable particularity matters complained of.

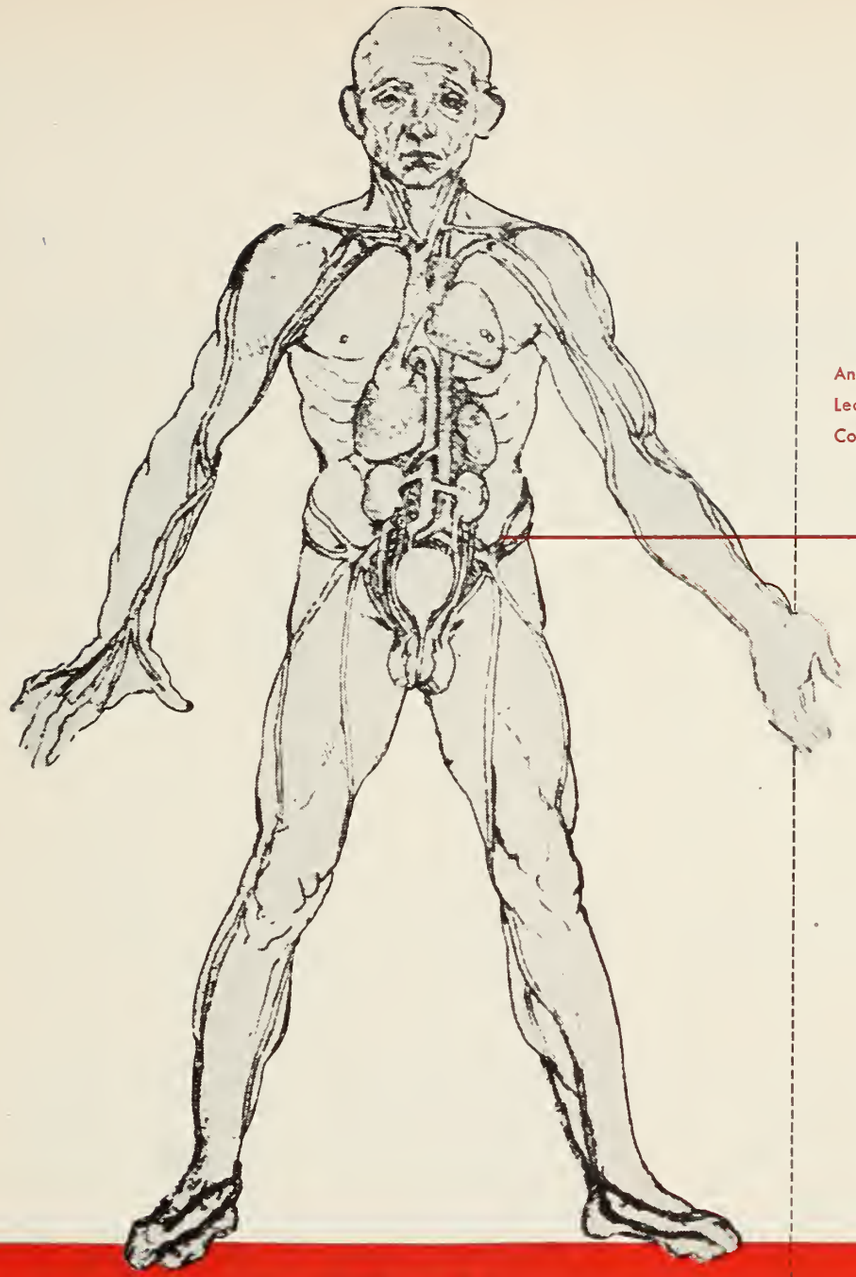
(d) A copy of the petition, together with notice of the time and place of hearing, shall be served on the affected member not less than thirty (30) days prior to the date of hearing.

(e) The affected member may file with his County Society written answer within fifteen (15) days after service upon him of a copy of such petition. He shall be accorded a fair hearing of the matters complained of before the Ethics Committee of his County Society and afforded an opportunity to present his defense, either in person or by counsel.

(f) A stenographic record shall be made of the proceedings at the hearing, and in case an appeal is taken by such member, a transcript thereof shall be prepared at the expense of the County Society for transmittal to the State Society. In such case, a copy of the transcript shall be furnished to the appellant as soon as may be.

(g) Any order of expulsion, suspension or other dis-

(Continued on Page 86)



Anatomic drawing by
Leanarda da Vinci—
Courtesy, The Bettmann Archive.

Leonardo da Vinci (1452-1519)

was well ahead of his time, for physicians of his day knew little of the function of the heart or the treatment of its diseases, although da Vinci's knowledge of such anatomy was extensive.

Physicians of today prescribe

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SEARLE

RESEARCH
IN THE SERVICE
OF MEDICINE

(Continued from Page 84)

cipline of a member shall be in writing, and shall set forth findings of fact, conclusions and reasons therefore. A copy of such order shall be served on the affected member as soon as may be.

(h) No such order shall become effective until the affected member has had an opportunity to avail himself of his rights of appeal as provided in these By-Laws.

(i) In County Societies having a Council, the procedure shall be: Written complaint, hearing before the Ethics Committee, a reference to The Council for adjudication, appeal to the Society as a whole, appeal to The Council of the State Medical Society and appeal to the Judicial Council of the American Medical Association.

(j) Each complaint, hearing or decision must give member at least thirty (30) days notice for rebuttal.

Sec. 4. A member of a County Society whose license has been revoked shall be dropped from membership automatically as of the date of revocation.

Sec. 5. A physician living near a county line may hold his membership in that County Society most convenient for him to attend, on permission of the Councilor or Councilors in whose jurisdiction he resides.

Sec. 6. Each County Society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, the moral and material conditions of every physician in the county; systematic effort shall be made by each member and by the County Society as a whole to increase the membership until it embraces every eligible physician in the county.

Sec. 7. At the Annual Meeting of each County Society or at a designated meeting of which ample notice has been given, each County Society shall elect Delegates or Alternate Delegates in conformity with the provisions of this Constitution and By-Laws to represent the County Society in the House of Delegates of this Society. The Secretary of the County Society shall immediately send a list of its Delegates to the Secretary of the State Society.

A Delegate, or in his absence the Alternate Delegate, becomes a member of the House of Delegates when properly registered and seated at the Annual Session following his election by the County Society. His membership in the House continues until the next Annual Session.

Sec. 8. The Secretary of each County Society shall keep a roster of its members and if practicable a list of non-affiliated physicians in the county, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this state, and such other information as may be deemed necessary.

Sec. 9. Each County Society shall appoint or elect a Committee on Legislation and Public Relations, and the County Secretary shall send the name and address of the Chairman to the Secretary of this Society.

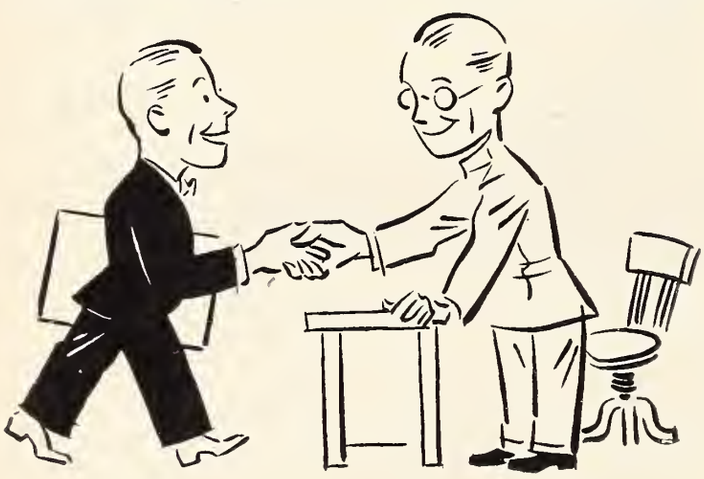
CHAPTER 13—DEFINITION OF SESSION AND MEETING

Section 1. A session shall mean all meetings at any one call.

Sec. 2. A meeting shall mean each separate convention at any one session.

CHAPTER 14—AMENDMENTS

Section 1. These By-Laws may be amended by a majority vote of the Delegates seated, after the proposed amendment is laid on the table for one meeting. These By-Laws bcome effective immediately upon adoption.



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Michigan's Department of Health

J. K. Altland, M.D., Commissioner

SUMMARY OF FAIR X-RAYS

One out of each 104 persons x-rayed at Michigan's county fairs and festivals this summer by the Department's mobile units had either active or healed tuberculosis.

Mobile units of the Department visited twenty-three fairs and festivals making chest x-rays of 43,640 persons. A total of 418 cases of active or healed tuberculosis were found.

Of the total number x-rayed, 858 had chest abnormalities, but additional follow-up showed that less than half of these had tuberculosis. Other abnormalities revealed by the survey included heart disease, pneumonia, silicosis, neoplasms and bone abnormalities.

A summary of the fair and festival survey during the 1947 season follows:

Fair or Festival	Total number x-rayed	Chest abnormalities	Tuberculosis (Active or healed)
Midland County Fair, Midland	2,355	28	5
Upper Peninsula Fair, Escanaba	2,540	44	16
Claire County Fair, Harrison	1,403	34	19
Mason County Fair, Ludington	2,185	47	7
Romeo Peach Festival, Romeo	719	9	25
Allen Park Festival, Allen Park	618	3	26
Allegan County Fair, Allegan	3,310	25	36
St. Joseph County Fair, Centerville	3,066	47	26
Blue Water Festival, Port Huron	1,316	45	29
Gratiot County Fair, Ithaca	1,283	37	12
Barry County Fair, Hastings	2,521	34	20
Shiawassee County Fair, Corunna	1,004	24	39
Isabella County Fair, Mt. Pleasant	1,561	29	12
Caro Fair, Caro	1,953	25	15
Berlin Fair, Marne	911	30	12
Hart Fair, Hart	1,701	53	26
Saginaw County Fair, Saginaw	2,167	44	5
Lenawee County Fair, Adrian	3,443	67	2
Hillsdale County Fair, Hillsdale	2,286	53	9
Van Buren County Fair, Hartford	1,008	44	22
Tulip Festival, Holland	1,007	16	22
Ionia County Fair, Ionia	2,142	48	15
Branch County Fair, Coldwater	3,141	72	18

Fairs and festivals which wish the services of a mobile chest x-ray unit of the Department for the next summer should contact the Department now.

MEASLES MODIFICATION

With measles appearing at a rate of 600 cases a week, with 1948 expected to be an epidemic year for the disease, and with an anticipated shortage of gamma globulin, the following suggestions are offered for the use of the preventive or modifying agent.

The ideal use of gamma globulin is to modify measles among children under six years of age when the actual date of exposure to measles is known. A dose of 1 c.c. of gamma globulin administered five to six days after a known exposure will result in a modification of the disease and the modified case will give the child permanent immunity to measles.

The only time gamma globulin should be used to prevent measles is when the exposed child is very young or very sickly. For these children, 1 c.c. should be administered immediately after exposure, and the treatment should be repeated every two weeks as long as the danger of exposure to measles exists.

The indiscriminate use of gamma globulin to create a temporary passive immunity merely results in extending the length of time during which measles will remain prevalent in the community. Its use early after exposure to the disease or prior to exposure results only in passive protection which wears out in two to three weeks, leaving the child entirely susceptible to measles.

The department's agreement with the American Red Cross, which is presently furnishing the gamma globulin, is that its use will be restricted to the modification or prevention of measles, preferably in the pre-school group of children. A shortage of the serum is expected because it is a by-product of production of serum albumin which is being made in lesser quantities by the Red Cross.

PUBLIC HEALTH MEETINGS ANNOUNCED

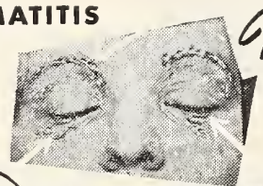
The 76th annual meeting of the American Public Health Association will be held in Boston the week of November 8, 1948, the Executive Board of the organization has announced. The 28th annual Michigan Public Health Conference will be held in Grand Rapids on December 1, 2 and 3, 1948.

MENINGITIS SERUM AVAILABLE

Hemophilus influenzae type B antiserum is again available for the treatment of influenzal meningitis. Since influenzal meningitis is relatively rare and since the antiserum is costly, supplies have been placed in only six areas rather than in all the Department's 110 distribution stations. Supplies will be maintained at the following points: Children's Hospital, Detroit; Herman Kiefer Hospital, Detroit; University Hospital, Ann Arbor; Michigan Department of Health, Bureau of Laboratories, Lansing; Northern Michigan Children's Clinic, Marquette; Munson Hospital, Traverse City; Western Michigan Di-

(Continued on Page 90)

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Frequent symptom of nail lacquer allergy



New AR-EX HYPO-ALLERGENIC NAIL POLISH
In clinical tests proved SAFE for 98% of women who could wear no other polish used.
At last, a nail polish for your allergic patients. In 7 lustrous shades. Send for clinical resume.

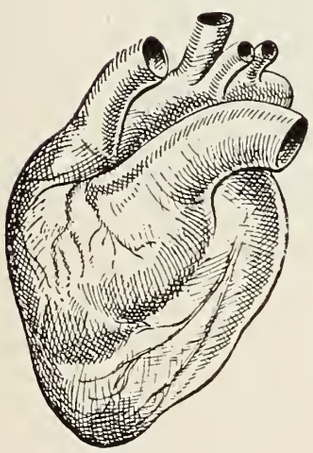


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For oral use 0.2 mg. tablets—vials of 30, bottles of 100 and 500; 0.1 mg. tablets—bottles of 100 and 500 • For intravenous injection: 1 cc. ampuls, 0.2 mg.



Purodigin has these advantages:

PRECISE DOSAGE: Purodigin (Digitoxin Wyeth) is absolutely uniform . . . standardized by weight, prescribed by weight.

LACK OF IRRITATION: Purodigin is concentrated—dosage is only *one thousandth* that of digitalis leaf. Nausea is rare.

ABSORPTION of Purodigin is virtually complete. Almost no irritating residue is left in the digestive tract.

SUSTAINED ACTION: Purodigin remains in the body as long as digitalis.

Try Purodigin—especially for those patients who do not easily tolerate digitalis leaf. Without interrupting treatment, simply prescribe 0.1-0.2 *milligram* Purodigin in place of 0.1-0.2 *gram* digitalis.

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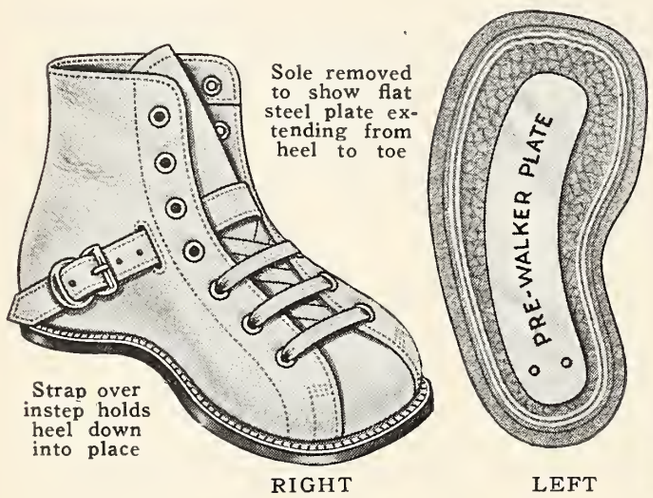
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SABEL'S PRE-WALKER CLUB FOOT SHOE

FOR INFANTS

SABEL'S CLUB FOOT SHOE
TRADE MARK REG. U.S. PAT. OFF.



THIS is the new Club Foot shoe designed and made for infants to be worn until the child can stand or walk alone. The "PRE-WALKER" Club Foot shoe can be worn by the infant at all times, and also can be kept on while the child is in bed. Its function is to keep the foot in the exact position that the physician has obtained.

As the infant progresses to the point of walking or standing alone and further corrections are required, then the regulation Sabel Club Foot shoe can be used until the fixation desired has taken place.

The Sabel line includes, in addition to the Pre-Walker, the Sabel Club Foot, Brace, Pigeon-Toe, and Surgical shoes.

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Opposite Women's City Club

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(Continued from Page 88)

vision, Michigan Department of Health, Bureau of Laboratories, Grand Rapids.

Other areas of the state can obtain this product by telephoning the Bureau of Disease Control, Michigan Department of Health, Lansing.

Since this product is of value only in the treatment of hemophilus influenzae type B meningitis, it is necessary that laboratory confirmation of the diagnosis be made before the serum is requested.

VD TRAINING OFFERED NURSES

Public health nurses in Michigan are now being offered a period of orientation in venereal disease nursing at the Rapid Treatment Center, Ann Arbor. Room and board will be furnished free at the center during the week-long course. Any public health nurse who has not received an application blank for the course, may have it by writing the Bureau of Venereal Disease Control, Michigan Department of Health.

PAMPHLET ON BED PATIENT CARE

A new pamphlet "Home Care of the Bed Patient" intended primarily for use by the family which must care for a patient in the home is available from the Department. The new pamphlet takes the place of "Home Care of the Communicable Disease Patient" which is outmoded and should be destroyed. The new pamphlet includes suggestions for the care of any person who is ill at home, whether a communicable disease case, a maternity case, or a long-term illness.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	Nov. 1947	Nov. 1946
Diphtheria	38	38
Gonorrhea	825	877
Lobar pneumonia	41	64
Measles	2135	131
Meningococcic meningitis	4	6
Pertussis	690	743
Poliomyelitis	44	106
Scarlet fever	308	512
Syphilis	1310	1403
Tuberculosis	431	448
Typhoid fever	9	1
Undulant fever	26	16
Smallpox	0	1

VISITORS STUDY IN DEPARTMENT

Public health personnel from South Africa, India, Colombia, Guatemala and Brazil visited and studied in the Department during late November and early December.

They included: Dr. David Ordman, director of the South African Institute for Medical Research, known for his typing of pneumococci in the battle against pneumonia among Transvaal gold miners; Dr. Julio Augusto Sierra, Chief of Biological Laboratories, Department of Health, Guatemala; Dr. S. S. Pillai, Assistant Superintendent, Public Health Laboratories, Travancore, India; Dr. Plinio M. Rodrigues, Chief Assistant, Institute Butan-

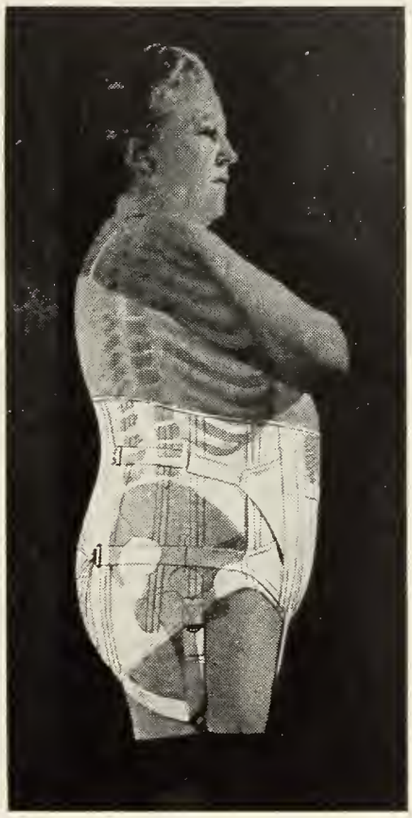
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EXCELLENT SUPPORT for the

PENDULOUS ABDOMEN



Patient with pendulous abdomen (skeleton indrawn).



Same patient after application of support (skeleton indrawn).

CAMP

Clinicians are calling attention to the ill effects of the pendulous abdomen more frequently than formerly.

Research discloses that the increased weight of the abdomen, carrying the center of gravity forward, puts strain on muscles of back and feet; that ultimately round shoulders and increased cervical and lumbar curves develop; that the diaphragm and abdominal viscera lie on a lower plane than normally; that eventually respiratory and circulatory symptoms appear.

S. H. Camp & Company, recognizing this proportionate irregularity and the frequency of its occurrence, has made supports for many years for these obese persons and for those in whom the obesity is largely confined to the abdomen.

Camp surgical fitters are taught to fit patients with pendulous abdomen in the reclining position; thus the intestines are redistributed to the sides and back of the abdomen and the support will hold them there.

The Camp Support illustrated is especially efficient in holding the viscera in their redistributed position by reason of the support given to the pelvis.

S. H. CAMP AND COMPANY • JACKSON, MICHIGAN

World's Largest Manufacturers of Scientific Supports

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Relax Tension
Relieve Pain
Reduce Congestion

—in chest conditions, neuralgia, sinusitis, myalgia, bronchitis, sprains, backache—

with the "heat therapy" of the Burdick Zoalite.

All models are equipped with the famous nonmetallic element which emits a high percentage of infra-red irradiation with a minimum of visible rays.

The DUAL ZOALITE, above, meets exacting clinical requirements for irradiation of large or small areas.

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Council Accepted Council on Physical Medicine American Medical Association Accepted

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4444 Woodward Avenue, Detroit, Michigan

(Continued from Page 90)

tan, San Paulo, Brazil; and Dr. Horacio Parra of Colombia.

NEW BREAST FEEDING FOLDER AVAILABLE

The Department has a limited quantity of Children's Bureau pamphlets on "Breast Feeding" which may be had for the asking.

CANCER PAMPHLET READY

The Department has prepared a new pamphlet, "What You Need to Know About Cancer," which is intended primarily for lay persons and is available without charge from the Department.

Woman's Auxiliary

WATCH US GROW!

Although the number of organized counties is gratifying, many of the unorganized ones could support an auxiliary. It is to accomplish this end that your organization chairman will direct her efforts this year. Let every member endeavor to have an unorganized county join us for a bigger and better Auxiliary. Both our president and I will be grateful for any help a member can give us to remove the white spaces from our map. Secure a "member at large" when it is impossible to organize a county. *She* may prove to be the spark that will interest many lay groups in the relationship of health to the general welfare.

* * *

Two new auxiliaries have been added, making a total of twenty-four. Calhoun County reorganized October 7, 1947; their president being Mrs. John Robbert, County Club Hills, R. 7, Battle Creek, Michigan. Mecosta-Osceola-Lake counties organized October 14, 1947, with Mrs. Gordon Yeo, president, 209 Rust Street, Big Rapids, Michigan.

There are twelve new members at large from unorganized counties: Mrs. Guy C. Kelar, 302 W. Green Street, Hastings (Barry County).

Mrs. Oscar Stryker, 310 32 E. Jefferson Avenue, St. Clair Shores (Macomb County).

Mrs. H. H. Learmont, Croswell (Sanilac County).

Mrs. C. W. Oakes, Harbor Beach (Huron County).

Mrs. S. R. Russell, St. Johns (Clinton County).

Mrs. W. E. Barstow, St. Louis (Gratiot County).

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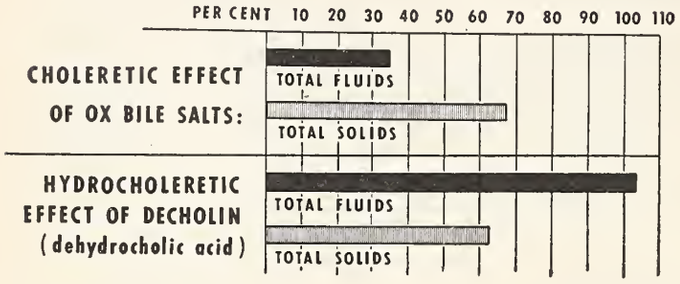
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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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In Memoriam

James Baird, M.D., Flint, Michigan. Born near Watford, Ontario, Canada in 1872. Graduated from the Detroit College of Medicine and Surgery in 1896. Practiced for fifty-one years. He was a member of the Genesee County Medical Society, and was elected to Emeritus Membership in the Michigan State Medical Society September 1946. Dr. Baird was a Charter Member of the MSMS Fifty Year Club. He passed away at the age of seventy-five, November 19, 1947, at Flint, Michigan.

* * *

Alexander Borland, M.D., Pontiac, Michigan. Born September 21, 1875, at St. Johnsbury, Vermont. Attended St. Johnsbury Academy and was graduated from the University of Vermont and the University of Louisville Medical School in Kentucky. Served in World War I as a Lieutenant in the Medical Corps. Was Health Director of Michigan State College for four years and also deputy coroner of Oakland County for two years. Member of the Oakland County Medical Society and the Michigan State Medical Society. Dr. Borland died at the age of seventy-two, October 2, 1947, in Pontiac, Michigan.

* * *

Charles N. Bottum, M.D., Marquette Michigan. Born January 15, 1878, in Westfield, Pennsylvania, and received his B.S. degree from Syracuse University in 1900 and his M.D. from the University of Illinois in 1903. Served as county health officer for contagious diseases in Marquette for over thirty years. Twice president of the Marquette-Alger County Medical Society and also served as president of the Upper Peninsula Medical Society. Dr. Bottom was elected to Life Membership in the Michigan State Medical Society in September of 1947. He passed away at the age of sixty-nine, in Marquette, Michigan, October 6, 1947.

* * *

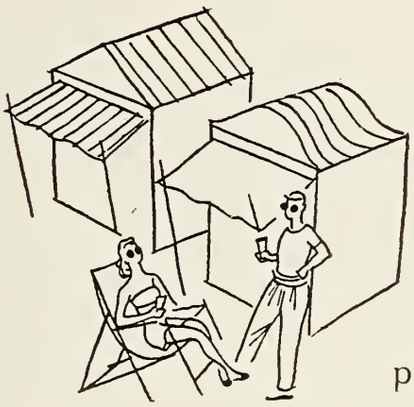
George H. Caldwell, M.D., Lakewood, Ohio. Born September 29, 1874, in Ontario, Canada. Attended State Normal School at Moorhead, Minnesota, and was graduated from the University of Michigan in 1903. For five years he held professorship of Physiology and Physiological Chemistry at University of North Dakota. Dr. Caldwell was a member of the Kalamazoo County Medical Society and was elected to retired membership in the Michigan State Medical Society September 26, 1946. He passed away at the age of seventy-three at Lakewood, Ohio, November 5, 1947.

* * *

William H. Carr, M.D., Holly, Michigan. Born March 21, 1876. Received education at Chicago Homeopathic Medical School and was graduated from the University of Illinois College of Medicine in 1904. Member of the Oakland County Medical Society and the Michigan State

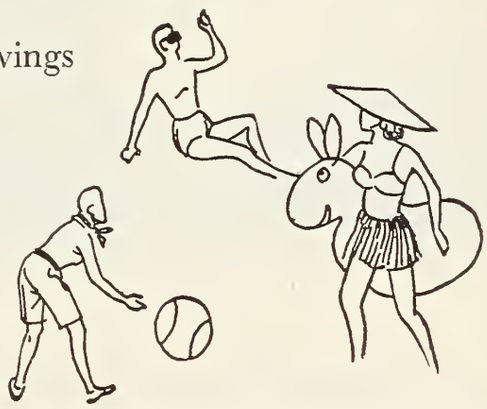
(Continued on Page 96)

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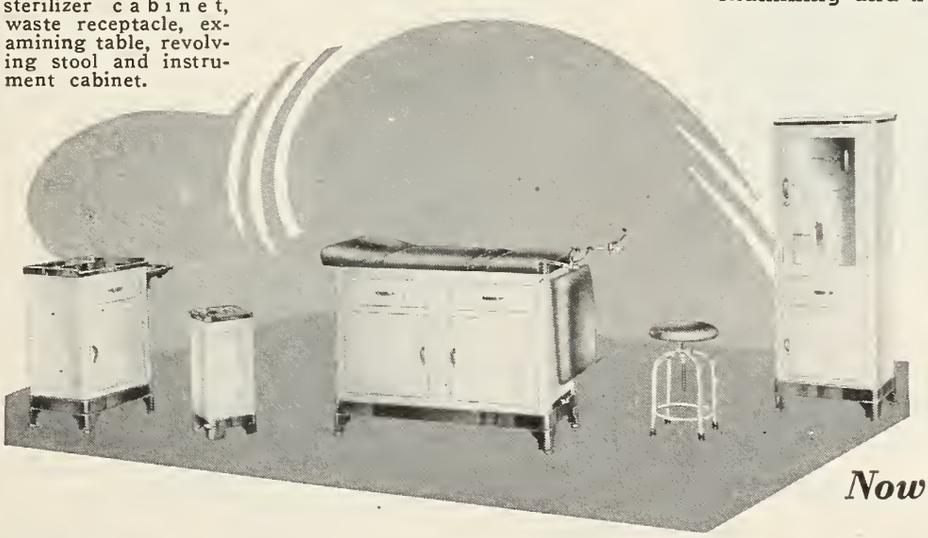
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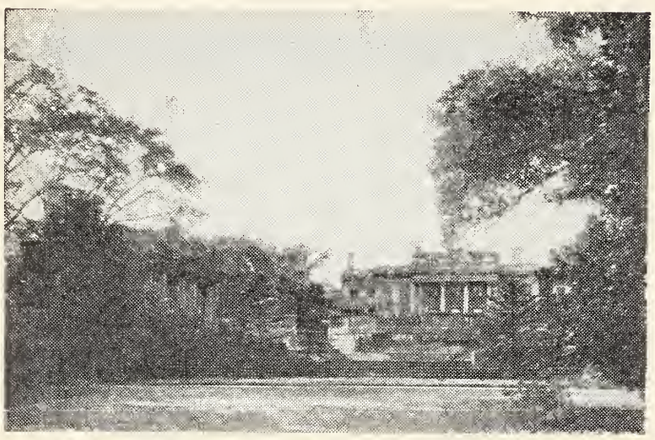
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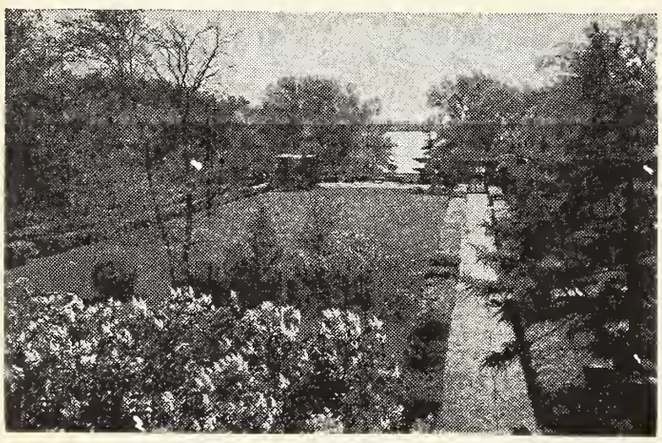
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(Continued from Page 94)

Medical Society. Dr. Carr passed away November 16, 1947, at Pontiac, Michigan, at the age of seventy-one.

* * *

Joseph H. Chance, M.D., Detroit, Michigan. Born 1888. Veteran of World War I. Member of the Wayne County Medical Society and the Michigan State Medical Society. Dr. Chance passed away October 26, 1947, at the age of fifty-nine, at Detroit, Michigan.

* * *

Wayne A. Geib, M.D., Rapid City, South Dakota. Word has been received that Dr. Geib, formerly of Detroit, Michigan, and a member of the Wayne County Medical Society and the Michigan State Medical Society up to the time of his resignation September 30, 1947, passed away recently at Rapid City, South Dakota.

* * *

William Francis Ertell, M.D., Kalamazoo, Michigan. Born 1875. Graduated from Michigan College of Medicine and Surgery, Detroit, in 1898, and the University of Michigan Medical School in 1900. Dr. Ertell was a member of the Kalamazoo County Medical Society and the Michigan State Medical Society. He expired at the age of seventy-two, September 29, 1947.

* * *

Dugal A. Galbraith, M.D., Lansing, Michigan. Born 1875, Ontario, Canada. Graduated from Detroit College of Medicine 1905. Director of Ingham County Welfare Medical Aid Program. Forty years a member of the Ingham County Medical Society. Served as president of the Michigan State Medical Society in 1930 and was a member of the state organization at the time of his death, August 1, 1947, at East Lansing, Michigan.

* * *

Gordan Albert Dumas, M.D., Shepherd, Michigan. Born 1920. Served his country in World War II. Killed west of Grand Rapids, Michigan, in an auto accident while returning from the Michigan State Medical Society annual session held in Grand Rapids. Dr. Dumas had expressed his intention, at the Annual Session, of joining the Gratiot-Isabella-Clare County Medical Society and the Michigan State Medical Society, upon his return to Shepherd, Michigan.

* * *

William Newton Kenzie, M.D., Richland, Michigan. Born 1875 at Battle Creek, Michigan, where he received his elementary education. Attended University of Michigan but education was interrupted by the Spanish-American War. He served as enlisted man. After discharge was graduated from the University of Illinois Medical College in 1900. Dr. Kenzie also served as major in the Medical Corps of the Army, World War I. He assisted President Harding in dedicating and unveiling monument to Francis Scott Key, author of the "Star-Spangled Banner" at Fort McHenry. He was a member of the Kalamazoo Academy of Medicine and was elected to Life Membership in the Michigan State Medical Society in September, 1946. Dr. Kenzie passed away October 19, 1947, at Kalamazoo, at the age of seventy-three years.

(Continued on Page 98)

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(Continued from Page 96)

Clarence A. Kretzschmer, M.D., Detroit, Michigan. Born 1896. Graduated from University of Michigan Medical School 1920. Member of the Wayne County Medical Society and the Michigan State Medical Society. Passed away October 17, 1947, at the age of fifty-two, at Detroit, Michigan.

* * *

Otto M. La Core, M.D., Muskegon, Michigan. Born 1875. Graduate of University of Tennessee Medical School and Detroit Medical College. After practicing 44 years, retired in 1946. Was a member of the Muskegon County Medical Society and was elected to Associate Membership in the Michigan State Medical Society in September, 1947. Dr. La Core passed away October 16, 1947, at Muskegon, Michigan, at the age of seventy-two.

* * *

George F. Lamb, M.D., Grand Rapids, Michigan. Born 1873 near Watford, Ontario, Canada. Graduated from University of Toronto Medical School in 1903. Served in Medical Reserve Corps in World War I. He was a member of the Kent County Medical Society and in September, 1946, he was elected to Life Membership in the Michigan State Medical Society. Dr. Lamb was seventy-four years of age at time of his death, October 6, 1947, at Grand Rapids.

* * *

Bertel T. Larson, M.D., Pontiac, Michigan. Born June 26, 1893, at Iron Mountain, Michigan. Received B.S. degree at the University of Michigan and M.D. at the University of Michigan College of Medicine in 1917. He served as lieutenant in the U. S. Navy Medical Corps during World War I. Dr. Larson was a member of the Oakland County Medical Society and the Michigan State Medical Society. He expired July 20, 1947, at the age of fifty-four, at Pontiac, Michigan.

* * *

Stanley J. Lassaline, M.D., Detroit, Michigan. Born Sandwich, Ontario, Canada, in 1893. Graduate of Detroit College of Medicine. Member of the Wayne County Medical Society and the Michigan State Medical Society. Dr. Lassaline passed away December 5, 1947, at the age of fifty-four, at Detroit, Michigan.

* * *

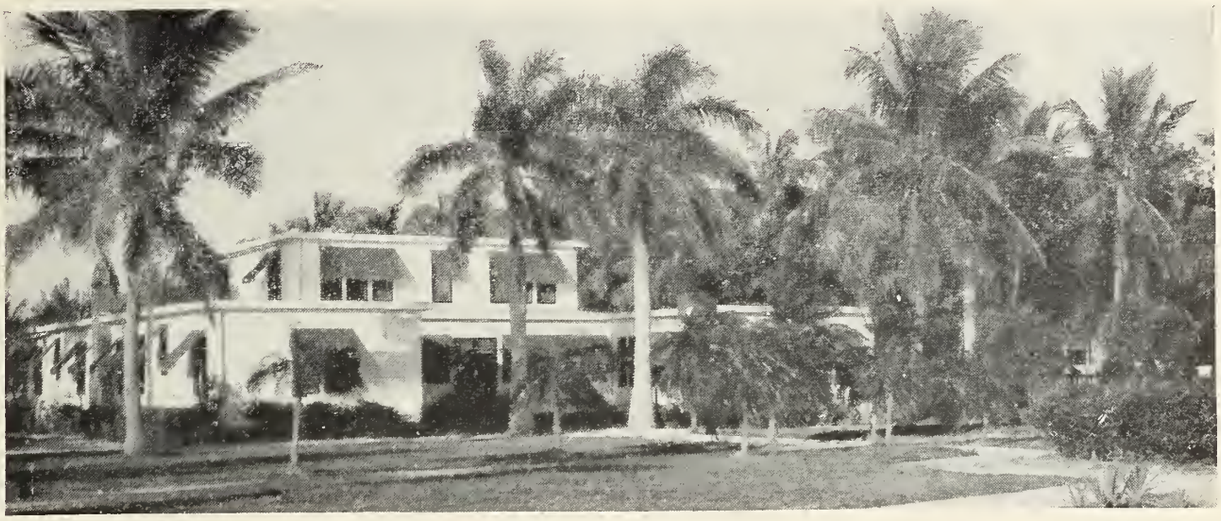
Clarence P. Lathrop, M.D., Hastings, Michigan. Born October 23, 1870. Received medical training at University of Michigan and Chicago College of Medicine. Aided in organization of the Barry County Medical Society which society he served three times as president. He was elected to Emeritus Membership in the Michigan State Medical Society, September, 1945, and was a Charter Member of the MSMS Fifty Year Club. He expired November 13, 1947, at the age of seventy-seven, at Hastings, Michigan.

* * *

William J. Lovering, M.D., Tucson, Arizona. Born in Beachville, Ontario, Canada, 1877. Received his medical education and degree from the Detroit Homeopathic

(Continued on Page 100)

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(Continued from Page 98)

College. He retired from practice in 1946 and moved to Arizona. He was a former member of the Wayne County Medical Society and the Michigan State Medical Society for twenty years. Dr. Lovering died August 22, 1947, at Tucson, Arizona, at the age of seventy.

* * *

George B. Lowrie, M.D., Detroit, Michigan. Born August 17, 1874. Graduate of the University of Michigan in 1898 and received his M.D. from old Detroit College of Medicine in 1901. Member of the Wayne County Medical Society and elected to Life Member in the Michigan State Medical Society in September of 1946. Dr. Lowrie died at the age of seventy-three, in Detroit, Michigan, September 21, 1947.

* * *

Reuben Maurits, M.D., Grand Rapids, Michigan. Born 1870 near Vriesland, Michigan. Graduated from Hope College, and University of Michigan Medical School in 1892. He was a member of the Kent County Medical Society and was elected to Emeritus Membership in the Michigan State Medical Society, September, 1946. Dr. Maurits was a Charter Member of the MSMS Fifty-Year Club. He was seventy-seven years old at the time of death, November 11, 1947, Grand Rapids, Mich.

* * *

Phillip E. Moody, M.D., Detroit, Michigan. Born 1879. Graduate of Detroit Medical School in 1902. For twenty-two years a member of the Wayne County Medical Society and the Michigan State Medical Society. Dr. Moody passed away November 11, 1947, at Detroit, Michigan, at the age of sixty-eight years.

* * *

M. Mary Rohn, M.D., Brighton, Michigan. Born 1853. Graduated from University of Michigan and received honorary degree from Harvard University for outstanding work in public health service. She at one time was a member of the Lapeer County Medical Society and the Michigan State Medical Society. Dr. Rohn passed away November 18, 1947, at Brighton, Michigan, at the age of eighty-four.

* * *

Samuel Schultz, M.D., Coldwater, Michigan. Born July 7, 1868, at Belleville, Michigan. Was graduated from Albion College in 1893 and Northwestern University Medical School in 1899. He enlisted in the Spanish-American War and served in World War I. Dr. Schultz was a member of the Branch County Medical Society and the Michigan State Medical Society, and served as president of the State Society. He expired August 12, 1947, at the age of seventy-nine, Coldwater, Michigan.

* * *

Alfred M. Switzer, M.D., Port Huron, Michigan. Born 1872. Graduate of the Detroit College of Medicine. Former resident of Owosso, Michigan, and member of the Shiawassee County Medical Society and the Michigan State Medical Society. Dr. Switzer passed away in Mt. Clemens, Michigan, at the age of seventy-five.

Say you saw it in the Journal of the Michigan State Medical Society

William J. Warner, M.D., Detroit, Michigan. Born 1913 in Detroit, Michigan. Graduate of University of Michigan Medical School. Served five years as captain in the Medical Corps of the Army. Member of the Wayne County Medical Society and the Michigan State Medical Society. Dr. Warner expired in Detroit, August 19, 1947, at the age of thirty-four.

* * *

Rollin C. Winslow, M.D., Battle Creek, Michigan. Born August 11, 1873, in LaPorte, Michigan. Entered Saginaw Valley Medical School in 1898 and received his medical degree from Northwestern University Medical College in 1902. Served in World War I. Was member of the Medical Corps Reserve. Active in Boy Scout Work and was awarded the Silver Beaver in recognition of his services. He was a close friend of the late Secretary of the Navy, Frank Knox, and former Governor Chase S. Osborn. Dr. Winslow was a member of the Calhoun County Medical Society and served as its president. He also served as president of the Michigan State Medical Society in 1936 and in September, 1947, was elected to Life Membership in the State Society. Dr. Winslow passed away at Battle Creek, November 21, 1947, at the age of seventy-four.

* * *

Elijah Van Camp, M.D., Battle Creek, Michigan. Born January 29, 1875, in Oxford Mills, Ontario, Canada. Received education at Hamline University, University of Michigan Medical School, and Northwestern University Medical School. Served in World War I as Major in the Medical Corps of the Army. He was a member of the Calhoun County Medical Society and was elected to Life Membership in the Michigan State Medical Society September, 1947. Dr. Van Camp passed away at Battle Creek, Michigan, at the age of seventy-two, on December 5, 1947.

VETERANS' EMERGENCY MEDICAL CARE PROGRAM

An emergency hospitalization program for veterans of World War II was established by the State of Michigan 64th Legislature, Regular Session of 1947 by Act 308 of the Public Acts of 1947 within the administration of the Michigan Veterans' Trust Fund, Board of Trustees, effective July 1, 1947. A similar program had been administered by the Office of Veterans' Affairs prior to July 1, 1947.

This emergency hospitalization program was immediately initiated by the Trust Fund and set up to furnish medical, surgical and hospital care for those persons who are eligible to receive assistance from the Michigan Veterans' Trust Fund. This care must be for an emergency. An emergency is considered to exist when the lack of immediate hospitalization would seriously endanger the veteran's and/or his or her dependent's life or health and when the emergency requires funds beyond the applicant's ability to pay from earnings, accumulated savings, or insurance.

(Continued on Page 113)

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What's What

Coming Meetings

1. Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit, March 10-11-12. H. H. Cummings, M.D., Ann Arbor, Chairman, will send copy of complete program to every MSMS member.

2. Michigan State Medical Society Annual Session, September 22-23-24, 1948, Book-Cadillac Hotel, Detroit. Program will be published in August number of JMSMS.

* * *

William Rottschaefer, M.D., Ann Arbor, is co-author of an article entitled "Brucella Agglutination Tests" which appeared in JAMA of December 13, 1947.

* * *

Renew your Federal Narcotic License on or before July 1, 1948. Send check to Bureau of Narcotics, Federal Bldg., Detroit.

The Detroit Department of Health has moved its offices from 3919 John R St. to 334 Bates at Jefferson Ave., Detroit.

L. Fernald Foster, M.D., Bay City, MSMS Secretary, addressed the Bay County Social Workers' Round Table, November 13, on "Medical Care and Hospital Plans."

* * *

W. B. Harm, M.D., Detroit, was appointed to the Committee on General Practice of Medicine by the AMA Board of Trustees.

* * *

The American College of Surgeons will hold its Thirty-fourth Clinical Congress at the Biltmore Hotel, Los Angeles, October 18 through 22, 1948.

* * *

Jerome Conn, M.D., Ann Arbor, has been reappointed by the MSMS Council as MSMS representative to the Michigan State Nutrition Council.

* * *

The American Medical Association has appointed a Committee of its Board of Trustees for the purpose of clarifying the resolution on hospital competition with private practice.

* * *

Joseph C. Molner, M.D., Deputy Commissioner and Medical Director, Detroit Department of Health, has an article entitled, "Epidemiology and Recent Developments in Poliomyelitis," published in *Minnesota Medicine* of November, 1947.

The Detroit Free Press of Sunday, November 2, ran a three-page picture story in its magazine section, portraying honor members of the Wayne County Medical Society.

* * *

E. S. Gurdjian, M.D., Detroit, was awarded the bronze medal of the American Roentgen Ray Society for his research on skull fractures.

Congratulations, Dr. Gurdjian!

* * *

Max M. Peet, M.D., Ann Arbor, was elected a member of the Committee on Scientific Exhibits of the American Medical Association by the AMA Board of Trustees on November 7.

* * *

The first International Poliomyelitis Conference will be held at the Waldorf-Astoria Hotel, New York, July 12-17, 1948, under the sponsorship of the National Foundation for Infantile Paralysis.

* * *

R. M. McKean, M.D., Detroit, was elected president of the Central Society for Clinical Research at the annual meeting of this Association in Chicago October 29. Congratulations, Dr. McKean!

* * *

Michigan Health Council.—You can look for activity on the part of the Michigan Health Council during the coming months. A campaign to develop Community Health Councils is rapidly taking shape.

* * *

E. W. Brubaker, M.D., Lansing, is MSMS representative on the Michigan State Health Education Committee, a committee of the State Department of Public Instruction, appointed by Eugene B. Elliott, superintendent.

* * *

Socialized Medicine.—"The Communist Party in America has stated, and the American Legion has documented the statement, that the keystone of a communist state is socialized medicine."—JOHN C. FOSTER, Executive Secretary, South Dakota State Medical Association.

* * *

O. A. Brines, M.D., Detroit, was chosen president-elect of the American Society of Clinical Pathologists in Chicago, October 27, at the 26th Annual Meeting of this Association.

Congratulations, Dr. Brines!

* * *

The Mid-West Radiologic Conference will be held at the Hotel Schroeder, Milwaukee, February 6-7, 1948. Robert R. Newell, M.D., Professor of Radiology, Stanford University School of Medicine, will be dinner speak-

(Continued on Page 104)

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(Continued from Page 102)

er on Friday, February 6. For program write: A. Mellamed, M.D., Secretary, 425 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

* * *

The International College of Surgeons (United States Chapter) will hold its Thirteenth Assembly and Convocation in Kiel Auditorium, St. Louis, November 15-19, 1948. The Sixth International meeting will be held in Rome, Italy, the week of May 18, 1948.

* * *

New Editor of New England Medical Journal.—Joseph Garland, M.D., Boston, has resigned as secretary of the Massachusetts Medical Society to take over the editorship of the *New England Journal of Medicine.* H. Quimby Gallupe, M.D., will serve as secretary of the state society until the annual meeting in May.

* * *

The Upper Peninsula Medical Society of Michigan will hold its annual meeting of 1948 in Ironwood on June 26-27. Officers for 1948 are: E. C. Eisele, M.D., Ironwood, president; W. H. Wacek, M.D., Ironwood, secretary, and M. J. Lieberthal, M.D., Ironwood, chairman of Committee on Registration.

* * *

"ADA Forecast" is the name of a new magazine for diabetics, making its debut with the January, 1948, issue. It is published by the American Diabetes Association. Subscriptions may be sent to the ADA at One Nevins Street, Brooklyn 17, New York.

* * *

Billion dollar corporation.—Among the billion dollar corporations in America, General Motors Corporation holds 15th place and the National Bank of Detroit ranks in 36th place. Metropolitan Life Insurance Company of New York heads the list with assets of over eight billion.

* * *

Surgery Gynecology and Obstetrics, December, 1947, has published an article entitled, "The Microscopic Criteria for the Diagnosis of Early Carcinoma of the Cervix Uteri," by Eugenia E. Gurskis, M.D., Donald C. Beaver, M.D., and Harry M. Nelson, M.D., F.A.C.S., Detroit, Michigan.

* * *

The Oakland County Medical Society held its December 3 meeting in one of the General Motors plants in Pontiac. Such in-plant meetings were recommended by the MSMS Committee on Industrial Health in 1945. The December 3 meeting in Pontiac included a plant walk and discussion of industrial hazards.

* * *

Amelia Minkley is executive secretary of the Washtenaw County Medical Society, with headquarters at 207 Fletcher Avenue, Ann Arbor, Michigan. Other executive secretaries of Michigan county medical societies are: Else Kolhede, Wayne County Medical Society, Detroit; Sara Burgess, Genesee County Medical Society, Flint, and Lucy W. Bartlett, Muskegon County Medical Society, Muskegon.



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The Chicago Medical Society will hold its fourth annual Clinical Conference at the Palmer House, Chicago, on March 2-3-4-5, 1948—the week preceding the second annual Michigan Postgraduate Clinical Institute, scheduled for the Book-Cadillac Hotel, Detroit, March 10-11-12, 1948.

* * *

The Midwestern Section of the American Congress of Physical Medicine will hold its annual sectional meeting and seminar February 26-27, 1948, at the VA Hospital, Hines, Illinois. For information, write Secretary C. O. Molander, M.D., Department of Physical Medicine, Michael Reese Hospital, Chicago 16, Illinois.

* * *

The National Jewish Hospital at Denver announces a program of Fellowships for postgraduate study in tuberculosis and allied diseases. Fellows will be appointed for three-month, six-month, or one-year periods. Information may be obtained by writing Allan Hurst, M.D., Medical Director, National Jewish Hospital, 3800 E. Colfax Avenue, Denver 6, Colorado.

* * *

The Michigan Society of Anesthetists will hold its regular monthly meeting on Wednesday, March 17, at the Olds Hotel, Lansing, at 6:30 p.m. (dinner). President Ivan B. Taylor, M.D., Detroit, will conduct the meeting; the program is being arranged by Chairman Bryce Stearns, M.D., Detroit, who promises an interesting presentation. For dinner reservations, contact Secretary Mary Lou Byrd, M.D., Butterworth Hospital, Grand Rapids.

L. Fernald Foster, M.D., Bay City, MSMS Secretary, was invited by the State Medical Society of Wisconsin to address its Council, in annual session, on "Modern Medical Public Relations" and also to act as leader of a panel discussion on this subject at its County Secretaries Conference, held in Madison, Wisconsin, on December 14.

* * *

"President to advocate mammoth health program.—Reliable sources in Washington report that when the President delivers his message to Congress in January, he will advocate a vast expansion of the Social Security Act, including a tremendous program for public health and medical care."—Secretary's Letter, American Medical Association, December 8, 1947.

* * *

A Doctor of Medicine at all athletic games.—The Ingham County Medical Society has arranged with the Lansing Superintendent of Schools to have a Doctor of Medicine assigned by the County Medical Society to attend all Lansing public school football and basketball games. The Lansing School Superintendent stated: "We are now assured that a competent physician will be instantly available to attend any injuries sustained by players on the field or the floor." Good public relations!

* * *

A great public trust.—Since its inception, and including the first ten months of 1947, Michigan Medical Service has paid to doctors for services to its certificate holders $22,949,924.01; and to veterans $1,345,136.98; mak-

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ing a total of $24,304,060.99. Until October 31, 1947, Michigan Hospital Service has paid to hospitals $47,568,-925.32. This makes a grand total of $71,872,986.31. That is the measure of the Public Trust. It is big business.

* * *

Work on the "Medical Associates" idea is proceeding apace. Material for the handsome brochure outlining the various vocations and professions covered by the field of Medical Associates has been completed. Publication is expected late in January. In the meantime, the MSMS Commission on Health Care has met with educational authorities to stimulate the setting up of additional courses in schools and colleges to provide for the education of these very much needed assistants to Doctors of Medicine.

YOUR PHOTOGRAPH

Joseph Merante, Jr., portrait photographer, 475 Fifth Ave., New York, will visit Michigan beginning January 2 to take photographs of additional members of the Michigan State Medical Society. Without any obligation to the individual member or to the Michigan State Medical Society, Mr. Merante has agreed to furnish a glossy print of the portrait of every member of the State Society who sits for a photograph. Through this arrangement, the MSMS archives will include a photograph of every member in the State, eventually. The cooperation of the membership is invited.

Holman Taylor, M.D., editor of the *Texas Medical Journal* and secretary of the Texas State Medical Society, died December 6, 1947, of coronary thrombosis when leaving a testimonial dinner given in his honor by his County Medical Society. Dr. Taylor, as a new editor, attended the first meeting of the State Secretaries and Editors at Saint Louis, Missouri, in 1910. Our editor has known and followed with interest the enormous energy of this gentleman and patriot. Dr. Taylor was a Brigadier General in command of troops during the first World War, not a medical officer.

* * *

World War II veterans receiving hospital care from Veterans Administration, as of August 1, 1947, totaled 52,032, an increase of nearly 100 per cent over the total for two years ago (August 1, 1945).

In addition, 47,417 veterans of World War I were being hospitalized, together with 2,881 from the Spanish-American War, 4 from the Civil War, 108 from other wars (Indian wars, et cetera) and a balance of 2,960 retired officers and enlisted men, and regular (peace time) establishment.

A grand total in VA hospitals of 105,432!

* * *

The eighth annual essay contest of the Mississippi Valley Medical Society will be held in 1948. The Society will offer a cash prize of $100, a gold medal, and a certificate of award for the best unpublished essay on any subject of medical interest (including medical

economics and education) and of practical value to the general practitioner of medicine. The manuscript, not to exceed 5,000 words, must be received by May 1, 1948. Further details may be secured by writing Harold Swanberg, M.D., Secretary, 209 W.C.U. Building, Quincy, Illinois.

* * *

Lunetta I. Powers, M.D., of Muskegon was recently honored by all the Muskegon County Medical Society physicians who served overseas in World War II—with the exception of B. W. Morse, M.D., formerly of Whitehall, who was killed in France.

The Muskegon physicians presented Dr. Powers with a plaque which read: "To Lunetta Powers for her efforts in helping us to keep our morale in war service." Dr. Powers endeared herself to the doctors of Muskegon County who were in uniform by a faithful correspondence during the entire period of World War II.

* * *

AMA Receives Pharmaceutical Award.—The American Pharmaceutical Manufacturers' Association's 1947 scientific award was made to the American Medical Association in recognition of its fundamental contributions to public health in the field of medical research. The award, voted by a committee of sixteen eminent scientists, was presented at a ceremony in the Waldorf-Astoria in New York on Tuesday, December 16.

This scientific award was made to the Mayo Foundation for Medical Education and Research in 1946; to the Rockefeller Institute for Medical Research in 1945; to the National Research Council in 1944 and to Sir Alexander Fleming and Sir Howard W. Florey of London in 1943 for their penicillin discoveries.

* * *

Rt. Reverend Monsignor John R. Mulroy, Vice President, Catholic Hospital Association—"If you but observe and enforce the first Principle of Medical Ethics; namely, that your prime object is to serve humanity, if you convince the public that organized medicine is fighting for good medical care that the people can afford, then you will have saved America on a very vital sector of the battlefront . . . government has an answer, its proponents claim; a solution to the problem of the high cost of medical care . . . "It is true their solution may be as farcical as that of the new doctor in 'Welcome Stranger.' "

* * *

Michigan Medical Service.—On October 31, 1947, there were 916,423 persons covered by Michigan Medical Service certificates. This is an increase of 75,431 in the first ten months of this year. Michigan Hospital Service at this same date had 1,199,049 certificate holders. In the past twenty-two months, since the payment for tonsillectomies was increased, there have been 25,964 cases, and that has cost $129,790 more than the old rate. In the case of appendectomies during the first six months of liberalized payments, there were 2,394 cases, and the extra cost was $59,850. On the day of the Board meeting, December 3, 1947, payments were being made to doctors on billings received in the office November 26,

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Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting February 2, March 1, March 29.
Surgical Anatomy and Clinical Surgery, two weeks, starting February 16, March 15.
Surgery of Colon and Rectum, one week, starting March 8, April 26.
Surgical Pathology, every two weeks.
FRACTURES AND TRAUMATIC SURGERY—Intensive course, two weeks, starting June 7.
GYNECOLOGY—Intensive course, two weeks, starting February 23, March 29.
Personal course in Vaginal Surgery, starting February 16, March 22.
OBSTETRICS—Intensive course, two weeks, starting March 15, April 12.
MEDICINE—Intensive course, two weeks, starting April 26.
Personal course in Gastroscopy, two weeks, starting March 29, April 19.
Electrocardiography and Heart Disease, four weeks, starting February 16, May 3.
CYSTOSCOPY—Ten-day course, starting January 5, January 19, February 2.
DERMATOLOGY—Formal course, two weeks, starting April 26.
Clinical course, every two weeks.

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1947. The only unpaid bills were those waiting for clarification and special action by the Medical Advisory Committee.

* * *

The General Practitioner, of Australia and New Zealand for October 15, 1947, has copied, entirely, an article, "Treatment of Urinary Tract Infections," by Reed M. Nesbit, M.D., and Stanley I. Glickman, which appeared in THE JOURNAL of the Michigan State Medical Society, June, 1947; also an article, "Anaesthesia in General Practice," by J. DePree, M.D., from the same issue.

This journal published in Australia and New Zealand contains about eleven articles which are copied from the United States, and elsewhere through the English speaking world.

We appreciate the honor.

* * *

Roy D. McClure, M.D., was honored at a testimonial dinner given by his surgical residents and associates, past and present, at the Detroit Club, November 22, 1947. More than fifty men who had had the major part of their surgical training under Dr. McClure at the Henry Ford Hospital attended the dinner. Among the speakers were Samuel F. Marshall, M.D., of the Lahey Clinic, Boston, who spoke on the subject "A Tribute to Roy McClure, the Surgeon"; Henry Harkins, M.D., Professor of Surgery, University of Washington Medical School, Seattle, Washington, whose topic was "An Appreciation of Roy McClure, the Administrator," and Charles F. Kettering. Edgar A. Guest read a poem composed for the occasion. At the conclusion of the program William A. Altemeier, M.D., of Cincinnati made a presentation of a television set.

* * *

"Grass Roots" Conference.—The AMA Board of Trustees again has approved a mid-year meeting of the National Conference of County Medical Society Officers.

This second so-called "grass roots" conference will be held during the interim session of the House of Delegates in Cleveland, Tuesday evening, January 6.

Copies of the program will be sent to all county medical societies within a short time. In keeping with the general practitioner theme of the interim session, the "grass roots" conference will be devoted primarily to problems of general practice and the general practitioner.

The executive committee in charge of arrangements is composed of A. M. Mitchell, M.D., Terre Haute, Indiana, chairman; B. O. Moork, Jr., M.D., Worthington, Minnesota; *D. B. Wiley, M.D., Utica, Michigan,* and F. J. Holroyd, M.D., Princeton, West Virginia.

* * *

"Freedom Has Its Price."—"Everything that is worth having has its price, and freedom is no exception. But it cannot be bought with money alone.

"Our forefathers made the initial payments on the freedom that they handed down to us. They paid in terms of blood, work, intelligent foresight and constant alertness to protect their liberty.

"The freedom to think, to work and to progress through earnest and able effort which these men and women be-

queathed to us is a precious possession. It has made America the most prosperous nation in the world.

"But freedom is never bought outright. The purchase installments run from generation to generation. The thoughtful and liberty-loving men and women of America are today again called upon to contribute to the maintenance of their heritage.

"That payment must be made by us as our forefathers made it through hard work and intelligent action."

—Committee for Economic Development

* * *

Michigan Association of Roentgenologists.—At a meeting in Jackson on Monday, December 8, 1947, the Michigan Association of Roentgenologists was reactivated. The Constitution and By-laws were redrafted and are in the hands of John Volderauer of Kalamazoo for final drafting and will be accepted subject to the editing of the Board of Directors.

The following officers were elected: president—Horace Porter, M.D., Jackson; vice president—John Volderauer, M.D., Kalamazoo; secretary-treasurer—R. B. MacDuff, M.D., Flint.

Board of Directors—three-year term, S. W. Donaldson, M.D., Ann Arbor; two-year term, L. E. Holly, M.D., Muskegon; one-year term, C. K. Hasley, M.D., Detroit.

The Members of the Board of Directors will be replaced by the retiring president each year until the rotation is set up.

Two meetings a year are planned. The first will be a scientific meeting, and the second of these each year will be the annual business meeting at which officers are elected.

* * *

The four points of a health program for school children, sponsored by the New Jersey Medical Society, its Woman's Auxiliary, and the State Department of Education of New Jersey, are:

1. Wherever possible, the present "routine," assembly-line physical examinations of school children should be abandoned in favor of individualized studies by qualified physicians, properly remunerated. The child should be stripped to the waist. For obvious reasons, one or both parents should be present at the examination.

2. As a minimum, the examinations should be held on admission to school, to the fourth grade, to the eighth grade and to the twelfth grade.

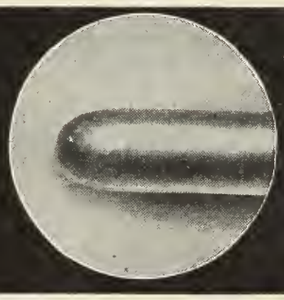
3. Each county superintendent should be required to add a psychiatrist to the county school system—possibly on a consultative rather than full-time basis. One psychiatrist might cover more than one of the smaller counties.

4. All school teachers and adult school personnel should be x-rayed for tuberculosis every year, rather than every third year, as at present.

* * *

Postgraduate Course in Pediatrics under sponsorship of MSMS, Michigan Department of Health, Department of Pediatrics and Postgraduate Medicine, University of

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Michigan, William J. Morrow, M.D., and James C. Beesley, M.D., of Ann Arbor, pediatric consultants in this program, will alternate for periods of four months at the University of Michigan and in the field. At the University of Miehigan they will conduct short postgraduate courses in pediatrics, and in the field they will be available for pediatric eonsultant services to practicing physicians.

The postgraduate courses in pediatrics will be of two weeks' duration and will be conducted for physicians in groups of three or four. Physicians will pay for their own maintenance in Ann Arbor, but there will be no charge for tuition. Physieians who wish to make application to take short courses in pediatrics should write to the Committee on Postgraduate Education, Michigan State Medical Soeiety, Room 2040, 1313 E. Ann Street, Ann Arbor, Michigan. Requests for field services of the eonsultants should be made to the Bureau of Maternal and Child Health, Michigan Department of Health.

* * *

Non-participation.—"The Government of the Province of British Columbia in 1936 passed a Public Health Act with the view of putting medicine under the control of the Province . . . "There was to be no choice of patient, nor was the patient to have any choice of doctor . . . "to date the legislation has not been put into force . . . "The reason it was not put into foree is because the College of Physicians and Surgeons advised the Government that it can pass any legislation it wishes in regard to State Medicine but that it cannot force one of the professions alone to aet at their bidding; 96% of British Columbia doctors voted against the Act and will have no part of it. . . . "We also drew the attention of the Government to the fact that it was not legislating the income of the legal profession or any other professions and this being a democratic country no one group could be forced to work against its will." So writes L. G. Wood, M.D., of Vancouver, British Columbia, under date of September 2, 1947.

There you have it . . . British Columbia has a State Medicine law on the books since 1936. . . . Yet, no physician has participated in the scheme, and this is 1947. . . . Non-participation *does* work—it *will* work.—*News Letter*, Association of American Physicians and Surgeons.

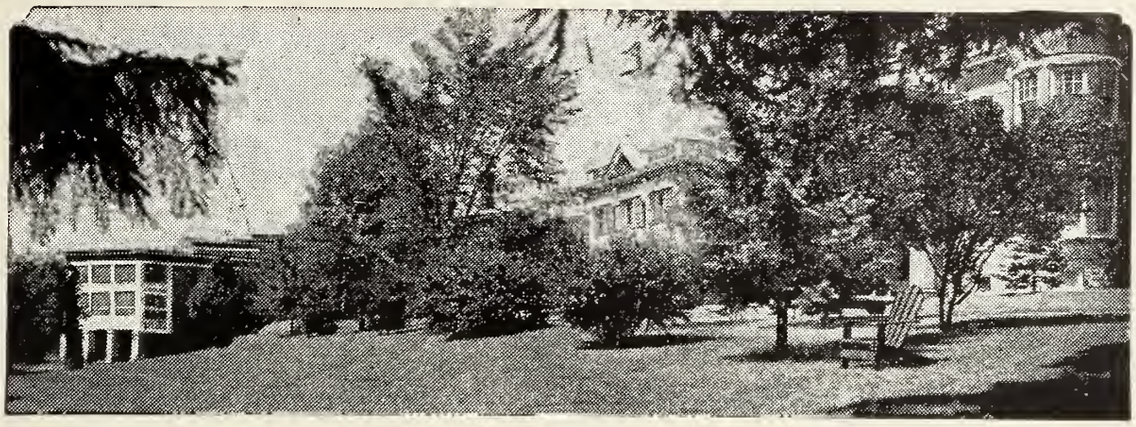
* * *

Still the same tree. "Each year the Wagner-Murray-Dingell Bill has reappeared, like Puck, in a new embodiment," writes Raymond Moley in the *Chicago Journal of Commerce*. "If a certain feature meets stiff and convincing criticism one year, the next edition amends that feature. But no matter how much it is pruned, it is the same tree. It is not insurance, for it is not self-supporting. It is not collective medieal care, for its beneficiaries do not pay for what they get. It is plainly government medicine. . . . Such a setup, of eourse, involves a New Dealers' delirium of bureaucracy. . . .

"Nothing was ever conceived or devised which would more effectively reduce the medical profession to dependence on the government and tie state and local agencies to the wheels of the federal government."

Mr. Moley prophesies that the Wagner-Murray-Dingell

Say you saw it in the Journal of the Michigan State Medical Society



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Bill "has no chance of passage this year, but it may well be the keystone of next year's Democratic platform. It is a threat which deserves far more public attention than it has been receiving," this reconstructed brain-truster concludes.—*Membership News Letter, Medical Society of New Jersey,* November 5, 1947.

* * *

Rural Health Conference Planned.—The third annual National Conference on Rural Health will be held in Chicago, February 6 and 7.

Featuring the health problems of the rural child, the conference will be sponsored by the Committee on Rural Medical Service of the AMA in co-operation with the American Academy of Pediatrics and representative farm organizations. The AMA committee, headed by F. S. Crockett, M.D., of Lafayette, Indiana, is composed of eleven physicians.

More than forty speakers are on the program for the two-day session. On the afternoon of the opening day, four farm youths, representing the National Farmers Union, the American Farm Bureau Federation, the National Grange and the National Co-operative Milk Producers Federation, will discuss the subject: "Rural Youth Looks at Health." The youths will be guests of the American Medical Association during their stay in Chicago.

Secretary Virginia Shuler says that "it is hoped that this meeting will give the farmer and the doctor an opportunity to exchange views so that together they can work out a program that will give the best possible care to every child."

Walter John Wilson, Sr., M.D., Detroit, was honored by his confrères on the staff of St. Mary's Hospital, Detroit, at a dinner held at the Detroit Athletic Club on December 3.

Representing the Michigan State Medical Society on this occasion, Councilor C. E. Umphrey, M.D., Detroit, presented the MSMS Resolution commending Dr. Wilson on his long and valued services to his profession.

Dr. Wilson was born February 6, 1876. He was graduated from high school in 1894 and from the Detroit College of Medicine and Surgery in 1897. He interned at Harper Hospital and began practice in the Motor City, limiting his work to cardiology beginning with the year 1913.

He was Chief-of-Staff of St. Mary's Hospital for a number of years and inaugurated the Cardiac Clinic in that institution. He was founder and first president of the Detroit Medical Club, and acted as Professor of Clinical Medicine and Professor of Materia Medica at Wayne University College of Medicine. Dr. Wilson's hobbies are hand ball and golf, both of which he still plays vigorously.

The greatest tribute to Dr. Wilson is that he is called "a doctor's doctor."

* * *

Postgraduate Pediatric Course for General Practitioners, University of Michigan.—The Michigan State Medical Society is sponsoring a program of postgraduate education in pediatrics in co-operation with the Departments



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of Pediatrics and Postgraduate Medicine of the University of Michigan and the Michigan Department of Health.

The course will be given under the direction of Dr. James Wilson, Chief of the Department of Pediatrics, and his staff, including Dr. William Morrow and Dr. James Beesley, pediatric consultants who have appointments on the staffs of both the Pediatrics Department of the University of Michigan and the Bureau of Maternal and Child Health of the Michigan Department of Health.

Beginning February 2, 1948, the course will be offered the first two weeks of each month to groups composing four to six physicians. It has been planned primarily for general practitioners, and the content of the course will vary with the expressed interest of the men in the group. Such subjects as the following will be covered: infant feeding; management of communicable disease, including immunization procedures; the newer use of antibiotics; demonstrations of newer laboratory techniques. The course will consist of ward rounds, clinical conferences, formal lectures, informal discussions, et cetera.

There will be no charge for tuition, but physicians will pay for their own maintenance in Ann Arbor. Physicians who wish to make application to take the course should write to Dr. H. H. Cummings, Chairman of the Committee on Postgraduate Education, Michigan State Medical Society, Room 2040, University Hospital, Ann Arbor, Michigan.

* * *

Therapeutic Trials Committee.—Dr. Harry Eagle, scientific director, National Cancer Institute, USPHS, Bethesda, Maryland, has been named to the Therapeutic Trials Committee of the AMA Council on Pharmacy and Chemistry to fill the vacancy created by the resignation of Dr. Barry Wood, Washington University, St. Louis.

Walton Van Winkle, Jr., M.D., secretary of the Therapeutic Trials Committee, reports that during the past year two contracts were completed, one with the Johns Hopkins Medical School for a study of a bronchodilator compound under the direction of Leslie N. Gay, M.D., and another with the University of Pennsylvania School of Medicine for study of an agent alleged to promote wound healing, the work to be under the direction of I. S. Ravdin, M.D.

The committee also has sponsored a study of streptomycin in granuloma inguinale by John Seabury, M.D., at Louisiana State University School of Medicine and has assisted him in obtaining supplies of streptomycin.

At the request of the National Foundation for Infantile Paralysis, Inc., the committee has explored the feasibility of conducting a clinical experiment to test the value of certain therapeutic measures in the treatment of acute poliomyelitis. A subcommittee composed of William T. Green, M.D., Boston, chairman, Derek Denny-Brown, M.D., Boston, Hugo Muench, M.D., Boston, and James L. Wilson, M.D., Ann Arbor, has rendered a report to the committee which also is being transmitted to the National Foundation for Infantile Paralysis. This report recommends that certain studies be undertaken.

Say you saw it in the Journal of the Michigan State Medical Society



Physical Medicine will be the subject of a one-day seminar to be held Wednesday, February 4, 1948, in Bay City. The lectures, to be held at Wenonah Hotel, will include the following:

H. Barbara Jewett, Director, Occupational Therapy, Wayne University, Detroit, Mich. "An Occupational Therapy Technician in General Practice."

Frederick G. House, M.D., Director, St. Joseph Hospital Dept. of Physical Medicine, Ann Arbor, Mich. "The Management of Cerebral Palsy."

Max Karl Newman, M.D., Director of Physical Medicine and Rehabilitation, Wayne University, Detroit. "Physical Medicine in Vascular Disease of the Extremities."

Walter M. Solomon, M.D., Head of Section on Physical Medicine, Western Reserve University, Cleveland, Ohio. "Physical Medicine in Arthritis."

The new Department of Physical Medicine at Bay City's General Hospital will be inspected by all registrants at 5:00 p.m. prior to the dinner at the Hotel at 7:00 p.m.

The evening talk on "The Management of Paraplegics —Spinal Cord Injuries" will be given by Louis B. Newman, M.D., Chief of Physical Medicine and Rehabilitation, Hines Hospital, Chicago.

Sponsors of the Seminar are the Bay County Medical Society, the Michigan State Medical Society's Committee on Postgraduate Medical Education, Wayne University, and the Staff and Administration of the Bay City General Hospital.

All MSMS members are cordially invited to attend the Seminar.

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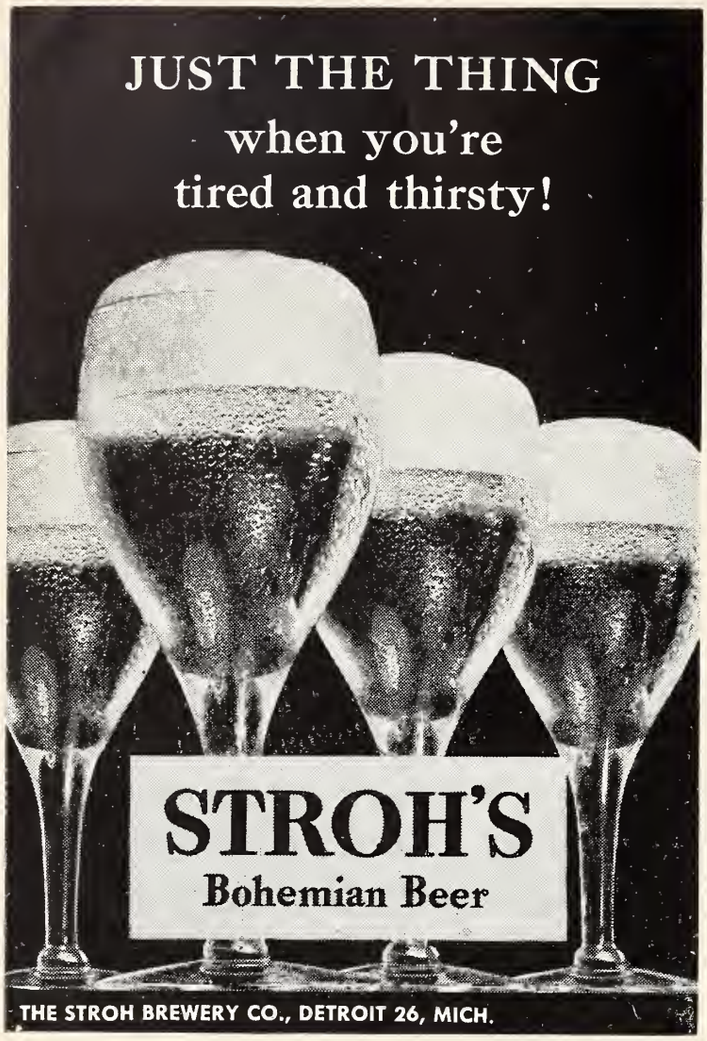
(Continued from Page 101)

The Michigan Veterans' Trust Fund, Board of Trustees, solicited the co-operation of the Michigan State Medical Society and was assured of the same excellent service and co-operation as was afforded the Office of Veterans' Affairs. An agreement was reached whereby all medical fees will be according to the minimum uniform fee schedule for governmental agencies officially adopted by the Michigan State Medical Society. Payment under this program will be effected through the local county Veterans' Trust Fund Committee.

The local county Veterans' Trust Fund Committee consists of one representative of the American Legion, one representative from the Veterans of Foreign Wars of the United States, one representative of the Disabled American Veterans, and one representative of the American Veterans of World War II.

Funds are distributed to the several county treasurers by the auditor general by warrant on the state treasurer and disbursements are made by the county treasurer on vouchers drawn by the county clerk based on orders filed by the county committee. Processing bills in this manner will enable doctors, hospitals, nurses and others concerned to obtain prompt payment for services rendered.

For further information, write the Michigan Veterans' Trust Fund, Board of Trustees, L. J. LaLone, Executive Secretary, 411 W. Michigan Ave., Lansing, Michigan.



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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

HEADACHE. By Louis G. Moench, M.D., Assistant Clinical Professor of Medicine, University of Utah School of Medicine; Internist, Salt Lake Clinic, Salt Lake City. Chicago: The Year Book Publishers, Inc., 1947. Price, $3.50.

One book devoted to headache is a welcome newcomer. The causes of headache are many. They may be located in the eye, the nose, the teeth. The search may be discouraging. This book tabulates the symptoms, the location; it gives sketches showing locations of headache stemming from nerves, sinuses, intracraneal lesions. Histamine headaches, migraine, neuralgic, and emotional headaches are all mentioned. For the doctor who wishes to know what to look for, this is a valuable book, small, but quite complete.

SEX POWER IN MARRIAGE, With Case Histories. A Realistic Analysis concerning the Sexual and Emotional Problems of Marriage. Edwin W. Hirsch, B.S., M.D. Chicago: Research Publications of Chicago (185 North Wabash), 1947. Price, $3.00.

This book is a study of the sexual relations of normally mated persons, who may have nothing wrong, or who may have many things disturbing them and interfering with sex life. The author has developed a philosophy that seems to be logical and brings results. He claims that impotent men and frigid wives are usually explainable, and can be helped. The book is well-written, contains many case reports, and involves much of psychology.

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY. By Francis H. Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School. Fourth edition. 512 pages, with 310 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price, $6.00.

Sanford Gifford, in his editions of this work, had in mind the medical student and the practitioner not primarily a specialist, and wrote the book with those needs in mind. The work is a clear and exact, but short exposition of the field of ophthalmology, diagnosis and treatment. There are enough illustrations to make the text clear, and controversial subjects are eliminated as having no place in such a book. The tools essential to ophthalmology are described, illustrated and their use given. The most modern thought is carried out, penicillin, biotics, newer belief in squint and the phorias, hypertensive disease, et cetera. The book is not too big. In fact, is so compact that one can read it in its entirety, with profit. Surgical treatment of the outstanding conditions, such as cataract, squint, ptosis, is given very superficially, but clearly, and is especially well-illustrated in enough steps to be a sure guide to operative success.

EAR, NOSE AND THROAT. Symptoms-Diagnosis-Treatment. By George D. Wolf, M.D., Assistant Clinical Professor of Oto'aryngology, New York Medical College. 149 illustrations, including 29 in color. Philadelphia: J. B. Lippincott Company, 1947. Price, $10.00.

This is a new book, printed on heavy non-gloss paper, with very readable well-spaced type, and illustrated by well-executed colorplates, other drawings and photographs. It is very creditably done from the standpoint of printing mechanics.

Say you saw it in the Journal of the Michigan State Medical Society

The first chapter, devoted to emergencies, tells and shows what to do, starting with nasal hemorrhages. In postoperative tonsillar hemorrhage, the author does not believe the clotting time gives any help. Salicylates, in any form, promote bleeding, unless accompanied with Vitamin K. Foreign bodies are described. The most frequent in the throat are fishbones.

An extensive part of the book describes tonsillectomy and its aftercare, and other throat diseases. Hoarseness and its causes, and examination get a chapter. The newer knowledge of impaired hearing and the fenestration operation are discussed, and indication for or against the operation are given. Several chapters are devoted to the blood dyscrasies, vitamins, allergies, biotics. The book is useful and avoids controversial subjects and long discussion.

PRACTICAL CLINICAL PSYCHIATRY. By Edward A. Strecker, A.B., A.M., Sc.D., Litt.D., LL.D., M.D., Professor of Psychiatry, School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, A.B., M.D., Professor of Psychiatry, University of Colorado, School of Medicine; Director, Colorado Psychopathic Hospital; Jack R. Ewalt, M.D., Professor of Neuropsychiatry; Director, Galveston State Psychopathic Hospital, University of Texas Medical Branch. Section on: PSYCHOPATHOLOGIC PROBLEMS OF CHILDHOOD. By Leo Kanner, M.D., Associate Professor of Psychiatry, Johns Hopkins University School of Medicine. Sixth edition. Philadelphia: The Blakiston Co., 1947. Price, $5.00.

This most recent edition of a well-known book on psychiatry should be a welcome addition to the physician's library. For many years Practical Clinical Psychiatry has been an accepted text and a reliable source of information for student, physician and specialist.

The organization of the subject matter is clear-cut and in logical sequence. The various syndromes are profusely illustrated with well chosen clinical reports. These clinical case records are concise and not overburdened with obscure psychiatric terminology.

The controversy existing between the several schools of thought in modern psychiatry can easily lead to great confusion to those not completely familiar with the divergent views. In this book, the authors have provided a well balanced and just presentation of this very difficult portion of psychiatry. This has been done without accentuating or minimizing important and perhaps significant conflicting views.

This book can be recommended to serious students and physicians as a readable, reliable and notably practical volume on psychiatry.

F.O.M.

THE OCULOROTARY MUSCLES. By Richard G. Sfobee, B.A., M.D., Instructor in Ophthalmology, Washington University School of Medicine, St. Louis, Mo. Illustrated. St. Louis: C. V. Mosby Company, 1947. Price, $8.00.

Motor anomallies of the eyes are a study in themselves, and have been the subject of research and teaching of many authors. The presentation in this book is new and novel. The author, however, has proven his case and presented the subject clearly and precisely. He gives the anatomy of the essential muscles and parts, with illustrations of actions, and he has worked out the actions which oppose each other in all eye movements. There are secondary actions of the muscles, synergistic,

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antagonistic and also yoke muscles. These, when understood, make the study of muscle action relatively simple. Latent or manifest deviations are given sections by themselves. Diagnosis is important and has relative attention. Treatment is nonsurgical or surgical as may be, but the reasons are given. A well-thought-out book.

SURGERY OF THE AMBULATORY PATIENT. By L. Kraeer Ferguson, A.B., M.D., F.A.C.S., Professor of Surgery, Graduate School of the University of Pennsylvania; Professor of Surgery, Woman's College of Pennsylvania; Surgeon Graduate Hospital University of Pennsylvania, Woman's Medical College Hospital, Philadelphia General Hospital and Doctors Hospital; Consulting Surgeon, U. S. Naval Hospital; formerly Chief of the Out-patient Department, Hospital of the University of Pennsylvania; formerly Chief of the Proctological Clinic, Hospital of the University of Pennsylvania and Philadelphia General Hospital. Section on FRACTURES. By Louis Kaplan, A.B., M.D., F.A.C.S., Associate in Surgery, University of Pennsylvania; Chief of Surgical Service II, Mt. Sinai Hospital; In Charge of the Fracture Division of the Surgical Out-patient Department, Hospital of the University of Pennsylvania. Second edition. 645 illustrations. Philadelphia: J. B. Lippincott Company, 1947. Price, $10.00.

This is primarily a system of office surgery. All those surgical procedures which can safely be done in the office are studied in rather complete detail. Etiology, classification, diagnosis are carefully given, and the treatment is detailed for office facilities. Caution is given that cases or conditions requiring extensive after care should not be included in this group. The things that can be successfully done, however, fill quite a large book. A portion of the book is devoted to fractures and dislocations to be done under local anesthetic. Methods of anesthesia, and operative and manipulative technique are given. Illustrations are profuse, 645 in all, and are excellent. This book has already become a standard. This second edition, revised since the war, has had many deletions, with the addition of penicillin and new methods. It is useful to the experienced surgeon as well as to the younger man starting his practice.

SYNOPSIS OF NEUROPSYCHIATRY. By Lowell S. Selling, M.D., Ph.D., Dr. P.H., F.A.C.P., Director, Division of Mental Health, Florida Department of Health; formerly, Attending Neuropsychiatrist, Deaconess Hospital; Associate Attending Neuropsychiatrist, Mt. Carmel Mercy Hospital, and Wayne County General Hospital; Director, Psychopathic Clinic, Recorder's Court, Detroit, Michigan; Assistant Professor of Criminology, Medical Jurisprudence and Social Hygiene, University of Illinois College of Medicine; Lecturer in Psychology, Wayne University; Visiting Professor of Psychology, Iowa State College. Second edition. Illustrated. St. Louis: The C. V. Mosby Co., 1947. Price, $6.50.

In this volume the entire subject of neuropsychiatry is reviewed in outline form. The limitations imposed by this approach to a complex segment of medical practice are apparent and are acknowledged by the author in the preface. The selection of material indicates a fairly complete synopsis. However, this wide coverage has led to brevity and undue simplification in the sections given to general discussion. This is particularly true in the introductory chapter on mental disease. Pursuing a "middle of the road" course, the author unduly simplifies and minimizes the contributions from the several schools of thought.

The organization of the section given to neurologic diseases is based entirely upon anatomic localization of the pathologic process. This arrangement does emphasize the important neurologic precept of localization, however, such an approach overlooks the educational value and the diagnostic aids obtained from a grouping of related disorders. Some confusion is apparent also in

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the repetition occurring when the disease process attacks more than one of the anatomic subdivisions of the nervous system.

A synopsis designed for use by the student and general practitioner should not, in the opinion of this reviewer, include controversial therapeutic advice. The recommendations for electro-shock in the treatment of psychoneurosis are in contradiction to general experience and the preponderance of evidence. The use of electro-shock in the regulation and control of epilepsy is distinctly controversial and hardly a matter for decision by the student or general practitioner.

A book of this type can be recommended only as an aid and can hardly be used or quoted as an authority because of its limitations.

F.O.M.

RESERVE COMMISSION, ARMY OF THE U. S.

Many former officers are confusing a temporary AUS Commission with a Reserve Commission. A temporary commission expires six months after the duration of the present emergency. A Reserve Commission is for a term of five years. Officers with a temporary commission may apply for a Reserve Commission in the grade held at time of separation from the service. If an officer was entitled to a terminal leave promotion (temp.) and did not receive it, he may apply for a Reserve Commission in the next higher grade. Officers interested in securing this promotion or a Reserve Commission should contact the Michigan State Senior Instructor, or write to 463 Federal Building, Detroit 26, Michigan.

ACTIVATION OF MEDICAL UNITS

The War Department is well aware that many medical officers felt they were not assigned to positions where they could be the most effective. A step in the right direction has been taken by making available for activation certain medical units on a Reserve status. These units will be both affiliated and non-affiliated types. These will be divided into Classes A, B and C—A, a full complement of officers and enlisted reservists; B, a full complement of officers and an enlisted cadre; C, a full complement of officers only.

There is, at present, a pay bill before Congress to pay for inactive duty on the basis of one day's pay and

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longevity for each two-hour training meeting. When this Bill is passed, it is planned that the A units will meet once each week, B units twice a month, and C units once a month. At present activated units are meeting a minimum of once each month.

The formation of these units gives the medical officer the chance to pick the spot he desires. In the event of mobilization, these units will be ordered into the service in their existing strength. Thus the Reservist has the chance to become familiar with his fellow Reservists and make the unit his own.

Units that have been activated during the past year in Michigan are:

Unit	*Commanding Officer*	*Station*
317th Hospital Center	Col. Grover C. Penberthy	Detroit
323rd General Hospital	Col. Wyman C. C. Cole	Detroit
397th Evac Hospital	Lt. Col. Keith F. Bennett	Kalamazoo
406th Evac Hospital	Col. Edward J. Grass	Grand Rapids
329th Med Collecting Co.	Capt. James H. Robinson	Detroit
460th Med Collecting Co.	Capt. Edward A. Hoffman	Detroit
321st Med Depot Co.	Maj. Ernest Kretschmer	Saginaw

Units requested but not activated as of this date:

Surgical Hospital Lt. Col. Clarence E. Johnson Dearborn

Units open for activation in any city in Michigan that the Reserve strength will warrant:

Unit	*Ev Cl*	*Off*	*EM*	*Rank of CO*
Evac Hospital	B	47	34	Col.
Station Hospital (400-bed)	C	21		Lt. Col.
Convalescent Camp	C	27		Lt. Col.
Field Hospital	A	22	182	Lt. Col.
Gen Disp	A	7	13	Major
4 Hospital Ship Platoons	C	2		Capt.

Any officers interested in activating any of the above units or in being assigned to one of the activated or requested units, should contact the Michigan State Senior Instructor, OR one of the sub-offices.

* * *

OPPORTUNITIES IN ORGANIZED RESERVE CORPS

Opportunities for certain professional men to qualify for direct commissions in the Organized Reserve Corps, has been opened up. This will cover doctors who have had no previous commission either in the Reserve or temporary commission in the Army of the United States.

For complete information, write Major Owen H. Taggart, CMP, Plans and Training Office, 463 Federal Building, Detroit 26, Michigan.

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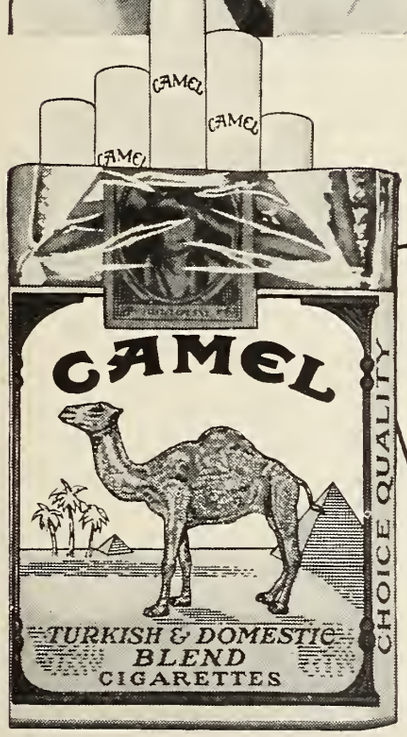


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Political Medicine

FREEDOM OR SERFDOM

C. E. UMPHREY, M.D.
Detroit, Michigan

OUR FOREFATHERS came to this country looking for freedom, and by establishing our Constitutional Government—a government of the people, by the people and for the people—guaranteed by law to every citizen the reasonable exercise of personal liberty. Great obstacles stood in the path of this unique adventure in government, but these people, who had been the victims of feudalism were willing to work, to suffer, and to sacrifice for the achievement of their ideals. For many years, the people of this Nation have reaped the benefits of our constitutional form of government. However, at times it seems we have become so accustomed to these advantages and blessings that we no longer appreciate them, and are no longer willing to fight for the preservation of our great heritage.

Many of our citizens now seem willing to exchange individual freedom—their very souls—for the benefits they think will come to them from a socialistic state. Many would sacrifice freedom itself for a mere promise of parities, subsidies, bonuses, grants, indemnities, support payments. Security with the least expenditure of effort has become their objective. Whether enough clear thinking leaders can be rallied to stop this present trend toward a socialistic or communistic state remains to be seen.

Socialism and Communism are the parallel roads which lead to a form of police control in which the individual gives up his personal liberties for vague promises of security and social and economic equality. The greatest menace which this Nation and the world face today is that our people will succumb to Communism.

Communism a Real Threat

This problem should be of great concern to us as doctors. The socialization of medicine is only a small part of the pattern of Communism. All private enterprise would be taken over. If we question this, we should read the Communist Manifesto[1] prepared in 1848 by Marx and Engels. A friend of mine said a short time ago: "All this talk about Communism and Socialism is just a wolf cry." We would like to believe that he is right, but the facts do not support him. Reliable authorities estimate that there are 282,618[2] sworn Communists in North America. My friend became truly concerned when he was told that there are ten "fellow travelers" for every member of the Communist Party, or a total of 2,826,180 workers for a cause which opposes our Government by every kind of espionage.

Perhaps the trend of Communism will become even more realistic by pointing out the fact that as of October 1, 1947, there were 3,835 Communist Party members in Ohio, 6,500 in Illinois, and 2,135 in our own State of Michigan.

If there is any doubt in our minds as to the objectives of the Communists, that doubt vanishes when we review the working principles of the party:

1. The working class must seize control from the bourgeoisie, or capitalist element.
2. Advocate violence if necessary.
3. Compel legislative recognition through organization.
4. Use the bourgeoisie or capitalist group, as they split when they try to defend their future interests.
5. Destroy all previous securities for, and insurances of, individual property.
6. Do not form a separate party opposed to other working classes or unions.
7. Overthrow the bourgeoisie and assume political power by the proletariat.
8. Abolish the family.
9. Use the system of education for indoctrination.
10. Support any organization that will further the cause.
11. Overthrow all existing social orders.

If you are eager to learn more about the efforts and successes of the Communists, I refer you to the

Presented at the meeting of the Michigan Physicians Committee, Detroit, Michigan, October 29, 1947.

1. Communist Manifesto, Karl Marx and Frederick Engels.
2. Map of the United States showing number of Communist Party members, by States.

(Continued on Page 132)

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FREEDOM OR SERFDOM

(Continued from Page 130)

bibliography which has been prepared by the Americanism Division of the American Legion. Every citizen owes a debt of gratitude to the American Legion for its continuing efforts to keep our great country free from the subversive elements which would destroy all of our democratic institutions.

To illustrate the methods and techniques of the Communist Party, I should like to detail a few examples. The Congressional Committee on Un-American Activities investigated and exposed the Young Communists League and brought such pressure to bear that this organization was disbanded on October 16, 1943. Undaunted by this rebuff, the Young Communists League was reorganized the next day under the name of American Youth for Democracy.[3] There is no doubt that the latter organization is the major front for Communism in the youth field. AYD has about sixty chapters in fourteen states, with a membership of 16,194 boys and girls. AYD's complete adherence to the Communist line dominates all of its activities. AYD wishes to attract the younger veterans, it claims a strong kinship with labor. AYD is affiliated with the Communistic World Federation of Democratic Youth which has its headquarters in Paris. We record these facts in the hope that each loyal citizen will understand that our children and young people are continuously exposed to these subversive influences and will be impelled to use whatever influence he has with our legislators and educational leaders to the end that AYD will be exposed and barred from our schools and campuses.

Infiltration Via School Textbooks

Parents and educators must be alerted to the subversive textbooks which are in use in our elementary and high schools. To cite a case in point, the California Society of the Sons of the American Revolution appeared before the legislature of that State to present charges against the Superintendent of Public Instruction, the Curriculum Commission and the State Board of Education, arising out of the use in the schools of California of subversive textbooks, most noteworthy of which were those in the "Building America" series.

In 1926 the American Historical Association received a grant of $300,000 from the Carnegie Corporation and spent this sum in five years of research. In 1934 the report, based upon this research, concluded that a new age of collectivism is emerging, and pointed out that public school education is the foundation of this Utopian "integrated order." The propaganda vehicle is to be courses of study in the social sciences, supplanting the traditional study of American history, geography, and civics. To further the cause of collectivism in the schools, Professor Harold Rugg of Teachers College, New York, prepared a series of fourteen textbooks;[4] eight for the elementary grades and six for high school students. Each of these textbooks was supplemented by a student's workbook and a teacher's guide in which both student and teacher are instructed how to interpret the textbook material. The following example of the Rugg technique is illuminating. A particular textbook deals with working conditions in the United States. The companion student's workbook then poses this question, "Is the United States a land of opportunity for all people?" and the the teacher's guide gives this unique answer to the question: "The United States is not a land of opportunity for all our people; for one-fifth of the people do not earn any money at all. There are great differences in the standards of living of the different classes of people. The majority do not have any real security." Many other illustrations from the youth field could be given, all of them clearly illustrating the fiendish devotion with which so-called progressive, liberal educators have for the Lenin statement, "Give me four years to teach the children, and the seed I have sown will never be uprooted."

After our youngsters leave school and enter business or become employed, they find that Communist fronts for businessmen and workers have also been provided. Posing as liberals and anti-fascists, some businessmen adhere to the Communist line. An example of the Communist front organizations in the business field, "The New Council for American Business," of which Mr. Wendell Berge,[5] former Assistant Attorney General of the United States, is the General Counsel. Frank Jaros is treasurer of the organization, and its secretary, Wesley E. Shorer, is the faculty member of the Communist Party's official school in Chicago.

3. Union Calendar No. 122, 80th Congress, 1st Session, Report No. 271.

4. Undermining our Republic, published by Guardians of American Education, Inc.

5. Counterattack—the news letter of facts on Communism, published by American Business Consultants, Inc., March 16, 1947.

(Continued on Page 134)



DISTINCTIVE

ESTINYL* (ethinyl estradiol) is distinctive among oral estrogens.

Ethinyl estradiol is a derivative of the true follicular hormone, alpha-estradiol. It is more potent, milligram for milligram, than any other oral estrogen, natural or synthetic, in clinical use today.

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FREEDOM OR SERFDOM

(Continued from Page 132)

Subversive Influence in Labor Unions

Almost everyone has become aware of the Communist attempts to infiltrate American labor unions. However, to illustrate the effectiveness of this technique, the following partial list of Communist controlled unions is quoted from *Counterattack*[6]—the newsletter of facts on Communism:

American Communications Assn.....CIO
Conference of Studio Unions (Hollywood Coalition) .....Mainly AFL
Food, Tobacco, Agricultural, and Allied Workers Union of America .....CIO
International Fishermen and Allied Workers of America .....CIO
International Longshoremen's and Warehousemen's Union .....CIO
International Fur and Leather Workers Union.....CIO
International Union of Mine, Mill and Smelter Workers .....CIO
National Maritime Union.....CIO
Transport Workers Union of America.....CIO
United Electrical Radio and Machine Workers of America .....CIO
United Farm Equipment and Metal Workers of America .....CIO
United Furniture Workers of America.....CIO
United Office and Professional Workers of America..CIO
World Federation of Trade Unions.....CIO

In addition, some seventy party line organizations are listed. It is healthy to note that many of the labor organizations have recently begun to resent communistic control and are analyzing conditions which existed during our greatest period of prosperity. One fact stands out; increased effort means increased production which gives us cheaper commodities, thus increasing by millions the number of people able to purchase, which means greater employment. This, in turn, means fewer on welfare and less tax demands. On the other hand, if we continue on the inflation road we now travel, we shall quickly reach the point, as they did in Germany a few years ago, where $250,000 will buy a postage stamp. Honest labor leadership can start us on the greatest prosperity this country has ever known. Of course, Russia will be strong in comparison if we weaken ourselves through Communistic subversive influence which is hurling us toward inflationary disaster.

What can be done to correct the present inflationary tendencies in this country today? We might follow very profitably the program of the National Trades Association which is as follows:

"We do not seek any special privileges."
"We seek equality before the law for everyone."
"1. The right of every worker to deal with his employer by collective bargaining through any agency he chooses.
"2. The right of every worker to deal with his employer directly as an individual.
"3. The right of every individual to work or not as he chooses.
"4. The right of every worker to go to and from his work unmolested.
"5. Equality under the law and the protection of minority right.
"6. Monopolistic activities of all groups whether employer or employe, must be controlled in the public interest."

The inescapable conclusion is:

1. The Wagner Act must be repealed.
2. Special immunities under antitrust laws must be repealed.

How does Russia get the complete co-operation she does? From 1919 to 1924 there is a matter of some 1,776,747 executions. According to Melgunou's book, the Sovet Secret Police boasted of their executions.[7] The list was made up of bishops, priests, teachers, physicians, officers, soldiers, policemen, landlords, office workers, laborers, and farmers. How do the Russians live now? The average weekly salary is $16.50. The cheapest women's shoes are $156.00 a pair. Those prices were current on July 19, 1946. This made it possible for the government to run a black market and drain off all the surplus savings. The current Russian five-year plan foresees one pound of rationed meat per month for the Russian worker but not before 1950. Please remember, however, he works only fourteen hours a day. As Joe Doakes said when he was deported for being a Communist, "Why didn't someone tell me about this?"

John Stuart Mill wrote a hundred years ago: "A people may prefer a free Government, but if from indolence, or carelessness, or cowardice, or want of public spirit, they are unequal to the exertions necessary for preserving it; if they will not fight for it when it is directly attacked, if they can be deluded by the artifices used to cheat them out of it; if by momentary discouragement or temporary panic, or a fit of enthusiasm for an individual, they can be induced to lay their liberties at the feet of even a great man, or trust him with powers which enable him to subvert their institutions; in all these cases they are more or less unfit for liberty; and though it may be for their good to

6. Counterattack—the news letter of facts on Communism, September 19, 1947.

7. Believe It or Not, by Robert Ripley.

(Continued on Page 136)

CLAIMS

VS.

DIFFERENCES

WHAT value have claims of superiority unless there is a difference in formula or process to justify such claims?

Take cigarettes for example.

PHILIP MORRIS Cigarettes are *made* differently. In the clinic as well as in the laboratory, the *advantages* of PHILIP MORRIS have been repeatedly observed, repeatedly reported by *recognized authorities* in leading medical journals. Yes, PHILIP MORRIS *claims* superiority . . . *and that superiority has been proved.**

May we suggest that your patients suffering from irritation of the nose and throat due to smoking change to PHILIP MORRIS—*the one cigarette proved definitely less irritating.*



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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

FREEDOM OR SERFDOM

(Continued from Page 134)

have it even for a short time, they are unlikely long to enjoy it."

The American Way of Life

The way we enjoy life in the United States is simply expressed by DeWitt Emery,[8] president of the National Small Business Men's Association, who says:

"Our American Way of Life is made up of many things—bathtubs and automobiles; big cities and small towns; farms and victory gardens; mammoth steel mills and village machine shops; colossal educational institutions and the little red school beside the road; churches and hospitals; railroads and air lines; chewing gum and ice cream; department stores and crossroad general stores; specialty shops and beauty parlors; pool rooms and race tracks; Hollywood, Broadway and the high school play; laughter and sorrow; eagerness and despair and people—millions of all kinds of people—gathered together from all over the world, drawn by the magnet of Freedom, Opportunity and Justice. Our American Way of Life provides each individual an opportunity to go as far and climb as high as his willingness to work, his skill, ingenuity and integrity will carry him.

"Our American Way of Life recognizes that the individual has the right to work when and where he wishes, the right to worship as he pleases, to speak his mind on any subject, to meet with his fellow men for any peaceful purpose, to be secure in his possessions and to have his day in a free court. It also recognizes that the individual is superior to the State, that our public officials are servants of the people and that they derive their just powers from the consent of the people.

"These things taken together created an atmosphere of freedom and an economic climate which made possible in the United States the greatest production and the establishment, for even the lowest paid workers, of the highest standard of living the world has ever known.

"Why? Because for more than one hundred and fifty years, free men in a free country have been working together to provide this better way of life. Let us hold what they have given us and go forward in the sure faith that the American Way of Life is the greatest blessing known to mankind any place on the face of God's earth."

Misleading Draft Rejection Figures

A tremendously important revelation of the unreliability of quoted government statistics—particularly with reference to rejections for "physical unfitness" of youths examined by the Selective Service Boards—was made recently by Maurice H. Friedman, Ph.D., M.D., of Washington, D. C. Testifying before the Senate Committee on Labor and Public Welfare, on June 25, 1947, on Senate Bills 545 and 1320, Dr. Friedman proved that the draft rejection figures used by proponents of compulsory sickness insurance were not only misleading but actually incorrect. Dr. Friedman, in presenting voluminous statistics of incontrovertible accuracy, declared:

"One of the chief arguments of the proponents of National Compulsory Health Insurance is that the medical services now available to our people are so inadequate that the need for some nationwide, comprehensive and compulsory medical insurance is urgent and immediate. According to this argument the status of the health of our citizenry is so deplorable that we can no longer afford to spend more time for the acquisition of more reliable data and more experience through local and varied experimentation with voluntary health insurance.

"Probably no point has been stressed more by the proponents of compulsory health insurance than the country-wide rejections by the Selective Service System. 'Working people are shocked, just as other people were, by the extent of physical unfitness that was revealed by the Selective Service examinations. . . . Of 16,000,000 youths examined, fully half were unfit for military service. The nature of the defects among the rejectees suggests that half to two-thirds of the defects could have been prevented or rehabilitated with timely care.'

"As can be seen from the following analysis of the Selective Service Data, the defects uncovered by the draft examinations have little significance with respect to the general health of this country. Any statement to the effect that one-half to two-thirds of such defects are preventable or remediable is utterly false.

The assumption has been made, usually tacitly, by the proponents of compulsory health insurance that the statistical sample examined by the draft boards was truly representative of the young adult male population of the United States. This is not quite true. Between Dec. 7, 1941, and Dec. 31, 1943, the draft boards selected about 10 million men for examination, and of these about 3.6 million were rejected; i.e., a rejection rate of about 36 per cent. During this period, however, *2.7 million men voluntarily enlisted in the armed forces.* If these men had gone through the selective service examination the total number of men examined would have been 12.7 million, and the rejection rate 28.4 per cent.

"After the enlistment of these 2.7 million men, 37.5 per cent of the residual available manpower was deferred because of essential occupation or dependency. Therefore the population examined by the Selective Service Boards was the male, adult population of the United States, minus those physically fit men who enlisted and minus the 37.5 per cent of the balance who were deferred *because of their particular value to war industry or to their families.*"

Government Propaganda for Socialized Medicine

The Honorable Forest A. Harness, Representative in Congress from the Fifth Indiana District,

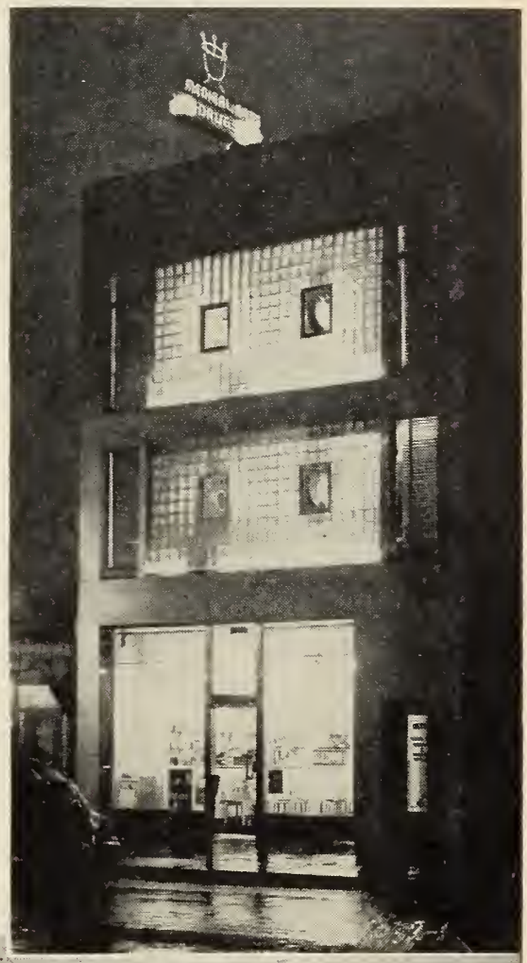
(Continued on Page 138)

8. Our American Way of Life, by DeWitt Emery.

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FREEDOM OR SERFDOM

(Continued from Page 136)

addressed the National Physicians Committee's National Conference of the Professions in Chicago on September 29, 1947. Congressman Harness is Chairman of the Subcommittee on Publicity and Propaganda of the House Committee on Expenditures in Executive Departments. His fight to curtail Communistic and Socialistic activities in Washington are clearly portrayed by the following quotations:

"The brand of dictatorship makes no difference—Communism, Fascism, Nazism, Socialism . . . all are alike, in that they enforce a system of State Medicine, or Political Medicine, as I prefer to call it.

"The amazing ramifications of the federal propaganda in behalf of Socialized Medicine have astonished me. How much of our total appropriations for health and welfare are being diverted to this sort of high-pressure propaganda, we do not yet know. But we do know that the amount is considerable. And before our inquiries are concluded, we shall hope to present for public consideration an itemized account of the total diversion of federal funds for this propaganda campaign.

"To our committee it seemed reasonable to ask why these agencies should be permitted to spend public money to generate an entirely artificial public demand for a system of Socialized Medicine in the United States, when all our experience through public opinion polls, and all our contacts with the medical profession indicate beyond question that the American people and the American medical profession insist upon maintenance of our traditional system of free medicine, under which we have attained the highest standards of service and scientific skill and proficiency ever recorded in the history of the world.

"All this Federally financed activity for Socialized Medicine heads up in the Bureau of Research and Statistics in the Social Security Board. Our Committee investigators have found in that bureau a veritable nerve center of Socialized Medicine propaganda for the entire world.

"But we are interested that funds appropriated by Congress for public administration shall not be diverted to a world-wide system of propaganda calculated to advance socialization of medicine the world around.

"But I, for one, do not intend to see this gigantic propaganda machine for Socialized Medicine financed entirely by funds secretly diverted from moneys appropriated by Congress for the legitimate functions of government.

"Suffice it here to say that the project was financed almost entirely by Federal funds, through the contributions of the participating government agencies—through the assignment of the so-called forum experts from the government bureaus, through the payment of travel expenses, and the providing of literature and mimeographed material for the meetings.

"Gentlemen, I am here to say that such a distorted conception of the public service in Washington must be uprooted by Congress.

"From these incidents it seems reasonable to conclude that some of our bureaus in Washington regard themselves as the protectors and defenders of the whole concept of compulsory national health insurance and Socialized Medicine. But, again, I want to repeat—that is not what Congress appropriated the money for!

"In our examination of the Bureau of Research and Statistics in the Social Security Board, we discovered that practically every argument, every pamphlet, every radio broadcast, and every statistical table, advocating Socialized Medicine originated primarily in the Social Security Board. Here is the world-wide nerve center of the movement for Socialized Medicine. Our committee found, and has so reported to Congress, that pamphlets prepared as to basic material in the Social Security Board were distributed to the general public by the CIO and AFL, the Farmers' Union, The Physicians' Forum and the Committee for the Nation's Health. All these pamphlets vigorously supported Socialized Medicine as embodied in the Wagner-Murray-Dingell bill. In several of the pamphlets, no matter by whom distributed, the language and the figures were the same.

Charges Against Tokyo Health Mission

"In a letter to Chairman Taber of the House Appropriations Committee, I made the following charges against the Tokyo Health Mission, which was dispatched to Tokyo by Government officials who have long been identified as proponents of Socialized Medicine schemes:

"1. That the health mission to Japan is composed entirely and exclusively of men long identified in the public record as advocates and proponents of Socialized Medicine not only in the United States but throughout the world.
"2. That the real purpose of this mission is to lay the groundwork for a system of Socialized Medicine in Japan.
"3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.
"4. That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by federal employes sent from Washington for that purpose.
"5. That General Douglas MacArthur does not favor —and does not approve—any plan to establish compulsory Socialized Medicine in Japan.
"6. That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Flak under date of June 14, 1947, is a gross misuse of public funds.
"7. That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of Socialized Medicine.
"8. That although the questions here involved are of

(Continued on Page 140)

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FREEDOM OR SERFDOM

(Continued from Page 138)

a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved."

Communism and Compulsory Sickness Insurance

"Suffice it at this time to report our firm conclusion, on the basis of the evidence at hand, that American Communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

"We must not fall into the attitude that all our opinions are made in Washington and handed down to us full fashioned. That is the way of dictatorship.

"Public Opinion must be maintained in its free and virile state—in full harmony with the great American tradition of liberty. If we do that by stamping out government propaganda at its roots, then we shall have rendered a great service, not only to medicine, but to the whole cause of liberty and freedom the world around.

"We all know that freedom is not free.

"We all know that bureaucratic power feeds upon itself—and upon the rights and privileges and liberties of the people.

"If we are to support and defend liberty and constitutional government in America, we must begin by keeping clean and undefiled the wellsprings of public information from Washington.

"Government propaganda poisons the well of public information.

"Government propaganda is illegal.

"Government propaganda is a method of dictators.

"Our purpose will be to uproot and destroy government propaganda wherever we may find it."

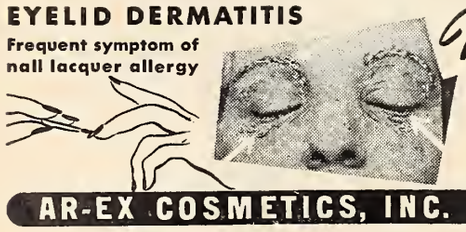
Is Representative Harness fighting just the subversive elements in our Government at the present time? Most decidedly not, he is fighting for preservation of the American way of life. Let us pause and take stock. Under that simple Constitutional system as originally conceived, in vogue nowhere else in the world, we developed here the highest and mightiest nation on earth, with a living standard for the common man by far the highest in world history, though Europe, Asia and Africa all had greater natural resources than we. Here, one's future was limited only by the extent of one's desire to work. With only 7 per cent of the world's population and 6 per cent of its land area, the United States possesses 80 per cent of the world's automobiles, 50 per cent of its telephones, 33 per cent of its railroad mileage, 30 per cent of its paved highways and 60 per cent of its life insurance policies. And before the war we consumed 75 per cent of the world's silk, 50 per cent of the world's coffee and 60 per cent of its rubber. All this did not come to pass because of some mysterious, unexplainable accident or because we did everything all wrong as our liberals and progressives and left wingers would have us believe.

A Timely Creed

If we doctors were to formulate a creed to fit the present times we might express ourselves as follows:

1. You can bring about prosperity by encouraging thrift.
2. You can help small men by aiding big men.
3. You can help the poor by not destroying the rich.
4. You can lift the wage earner up without pulling the wage payer down.
5. You can keep out of financial trouble by spending less than you earn.
6. You can further the brotherhood of man by discouraging class hatred.
7. You can establish sound social security if you are not encumbered by debts.
8. You can build character and courage by supporting man's initiative and independence.
9. You can help men permanently by urging them to do what they can and should do for themselves.
10. You can help to preserve ever improving medical care by offering your solicitied constructive criticisms and by demanding that Doctors remain forever free of State control!

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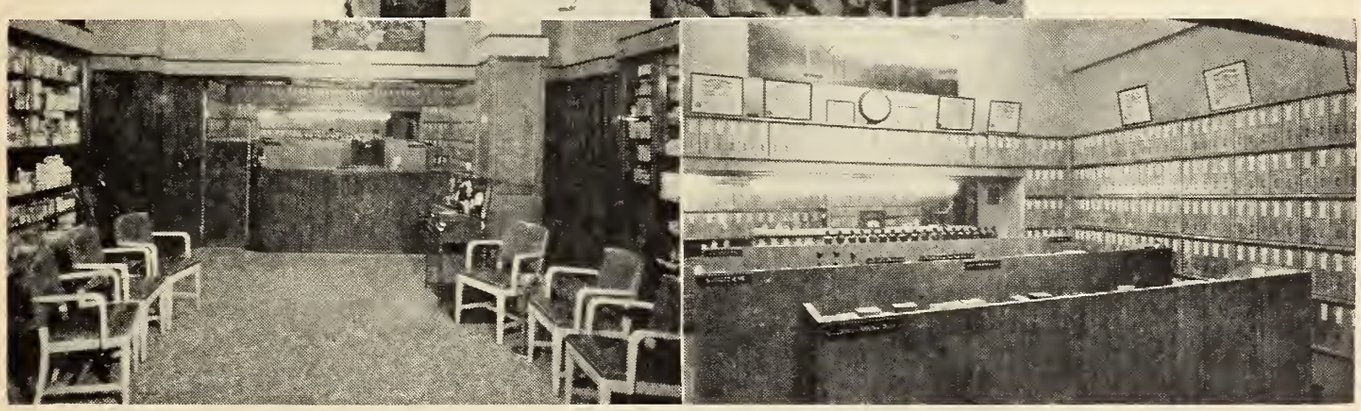
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Michigan Postgraduate Clinical Institute
Second Annual Session

Book-Cadillac Hotel, Detroit, Wednesday-Thursday-Friday, March 10-11-12, 1948

This Institute will be presented under the sponsorship of the Michigan State Medical Society in co-operation with the Wayne County Medical Society, the University of Michigan Medical School, Wayne University College of Medicine, University of Michigan Department of Postgraduate Medicine, and the Michigan Foundation for Medical and Health Education.

WEDNESDAY, MARCH 10, 1948

8:30 AM *Registration*—Fifth Floor, Book-Cadillac Hotel
Exhibits Open—Fourth Floor, Book-Cadillac Hotel

First Assembly

Grand Ballroom

L. Fernald Foster, M.D., Bay City, *Chairman*

8:55 AM Welcome.....P. L. Ledwidge, M.D., Detroit, President MSMS
C. L. Candler, M.D., Detroit, President, Wayne County Medical Society
9:00 "The Management of Obstetrical Patients".....Harold Henderson, M.D., Detroit
9:20 "Differential Diagnosis of Tumors of the Chest"..Cameron Haight, M.D., Ann Arbor
9:40 "Medical Diagnosis of Congenitally Anomalous Heart"
Saul Rosenzweig, M.D., Detroit
10:00 Intermission to View Exhibits
11:00 "Pulmonary Edema".....R. M. Eaton, M.D., Grand Rapids
11:20 "Diagnosis and Management of the Slipped Epiphysis"
A. G. Goetz, M.D., Detroit
11:40 "Useful Drugs in the Management of Allergic Diseases"
J. M. Sheldon, M.D., Ann Arbor

12:15 PM LUNCHEON, Crystal Ballroom

R. D. McClure, M.D., Detroit, Chairman

1:15 PM THE R. B. SYKES LECTURE: "Diagnosis and Treatment of Breast Tumors"
F. A. Coller, M.D., Ann Arbor

Second Assembly

Grand Ballroom

A. F. Bliesmer, M.D., St. Joseph, *Chairman*

2:00 PM "Control of Intractable Pain".....W. H. Meade, M.D., Lansing
2:20 "The Present Status of Anti-Thyroid Drugs".....W. S. Reveno, M.D., Detroit
2:40 "Quantitative Serologic Tests. Their Use in the Diagnosis of Syphilis and Follow-up after Intensive Treatment".....L. W. Shaffer, M.D., Detroit
3:00 Intermission to View Exhibits
4:00 "The Treatment of Common Skin Diseases".....E. P. Cawley, M.D., Ann Arbor
4:20 CLINICAL X-RAY CONFERENCE—Subject: Near Misses in X-Ray Diagnosis. Conducted by F. J. Hodges, M.D., Ann Arbor

Third Assembly

Grand Ballroom

8:00 PM Question Box
E. D. Spalding, M.D., Detroit, *Moderator*
D. H. Kaump, M.D., Detroit
M. F. Osterlin, M.D., Traverse City
W. F. Seeley, M.D., Detroit
H. J. Vanden Berg, M.D., Grand Rapids
10:00 SMOKER and ENTERTAINMENT. Host: Michigan Postgraduate Clinical Institute

THURSDAY, MARCH 11, 1948

8:30 AM *Registration*—Fifth Floor, Book-Cadillac Hotel
Exhibits Open—Fourth Floor, Book-Cadillac Hotel

Fourth Assembly

Grand Ballroom

C. G. Clippert, M.D., Grayling, *Chairman*

9:00 AM "The Use of Atomic Energy in Medicine".....K. E. Corrigan, Ph.D., Detroit
9:20 "The Present Trends in Treatment of Thrombophlebitis and Phlebothrombosis"
R. W. Buxton, M.D., Ann Arbor

9:40 "Endometriosis".....R. L. Haas, M.D., Ann Arbor
10:00 Intermission to View Exhibits
11:00 "Preanesthetic Medication".....N. M. Bittrich, M.D., Detroit
11:20 "Management of the Acute Abdomen".....Matthew Peelen, M.D., Kalamazoo
11:40 "Management of Acute Arthritic States".....W. D. Robinson, M.D., Ann Arbor

12:15 PM LUNCHEON, Crystal Ballroom

H. A. Kemp, M.D., Detroit, Chairman

1:15 "Medical Participation in Public Health".....H. F. Vaughan, Dr. P.H., Ann Arbor

Fifth Assembly

Grand Ballroom

E. I. Carr, M.D., Lansing, *Chairman*

2:00 PM "Psychosomatic Medicine".....R. W. Waggoner, M.D., Ann Arbor
2:20 "Feeding Problems in Infancy and Childhood"....Frank Van Schoick, M.D., Jackson
2:40 "Intestinal Obstruction".....R. J. Noer, M.D., Detroit
3:00 Intermission to View Exhibits
4:00 "The Acutely Red Eye".....A. D. Ruedemann, M.D., Detroit
4:20 CLINICAL-PATHOLOGICAL CONFERENCE—Subject: A Surgical Case. Conducted by O. A. Brines, M.D., Detroit

Sixth Assembly

Grand Ballroom

8:00 PM Panel Discussion on "First Aid to Acutely Injured Patient"
G. C. Penberthy, M.D., Detroit, *Moderator*
G. J. Curry, M.D., Flint
H. F. Falls, M.D., Ann Arbor
C. R. Keyport, M.D., Grayling
F. N. Smith, M.D., Grand Rapids
William Tuttle, M.D., Detroit
J. E. Webster, M.D., Detroit

FRIDAY, MARCH 12, 1948

8:30 AM *Registration*—Fifth Floor, Book-Cadillac Hotel
Exhibits Open—Fourth Floor, Book-Cadillac Hotel

Seventh Assembly

Grand Ballroom

Merrill Wells, M.D., Grand Rapids, *Chairman*

9:00 AM "Diagnosis and Treatment of Peptic Ulcer".....R. K. Dixon, M.D., Detroit
9:20 "Cancer of the Uterus".....H. M. Nelson, M.D., Detroit
9:40 "Management of the Patient in the Menopause"..H. H. Cummings, M.D., Ann Arbor
10:00 Intermission to View Exhibits
11:00 "Vomiting in Infancy".....H. A. Towsley, M.D., Ann Arbor
11:20 "Office Urology".....H. L. Morris, M.D., Detroit
11:40 "Poliomyelitis".....F. H. Top, M.D., Detroit

12:15 PM LUNCHEON, Crystal Ballroom

Arch Walls, M.D., Detroit, Chairman

1:15 "Problems of the General Practitioner in the Small Town"..J. S. DeTar, M.D., Milan
"Problems of the General Practitioner in the Large City"
W. B. Harm, M.D., Detroit

Eighth Assembly

Grand Ballroom

W. S. Jones, M.D., Menominee, *Chairman*

2:00 PM CLINICAL-PATHOLOGICAL CONFERENCE—Subject: A Medical Case. Conducted by F. W. Hartman, M.D., Detroit
2:40 "Pneumonia and its Complications".....L. G. Christian, M.D., Lansing
3:00 Final Intermission to View Exhibits
3:40 "The Recognition and Management of Tumors of the Lung"
R. H. Meade, Jr., M.D., Grand Rapids
4:00 "Hypertension and its Management".....F. A. Weiser, M.D., Detroit
4:20 "Endocrinology in Gynecology".....J. P. Pratt, M.D.,Detroit
4:40 "Office Treatment of the Nose and Accessory Sinuses"
A. C. Furstenberg, M.D., Ann Arbor

End of 1948 Institute

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Founded 1813
SCHOOL OF MEDICINE

Easter Seals Support A Society That Serves

Since 1934, Easter Seals and Easter Season have been symbolically synonymous. Easter is the period of Hope; Easter Seals offer the fulfillment of the hopes and prayers of thousands of crippled children in Michigan.

Beginning February 28 and lasting through Easter Sunday, March 28, over 110,000,000 Easter Seals in sheets of one hundred will be on their missionary journey throughout Michigan giving everyone an opportunity to contribute. Money from the sale of the Easter Seals is administered by the Michigan Society for Crippled Children and Disabled Adults, Inc.

At this time, when opportunities to contribute to worthy charitable organizations abound, it is interesting to note that the Michigan Society for Crippled Children and Disabled Adults has distinguished itself by rendering services far in excess of reasonable expectations. The MSMS recognized this Society's outstanding efforts by awarding, on September 24, 1947, the first Distinguished Health Service Award ever to be given to any lay organization. The Award read as follows:

"In recognition of outstanding contribution to the cause of health the Michigan State Medical Society hereby awards to the Michigan Society for Crippled Children and Disabled Adults, Inc., the Distinguished Health Service Award. The Michigan Society for Crippled Children and Disabled Adults has pioneered for twenty-five years in providing care for all types of physically handicapped persons in Michigan: By its broad program, highly ethical procedures and co-operative spirit towards all who labor for better medicine it has succeeded in meeting a great social and economic need, to the benefit of the people."

Let us review some of the activities of the Easter Seal society, the more commonly known name of the Michigan Society for Crippled Children and Disabled Adults.

Easter Seals Support Rheumatic Fever Program

The Rheumatic Fever Program of the MSMS is wholly financed by the Easter Seal society. This unique program has already developed twenty-eight Centers in Michigan to which some 1,000 patients have been referred. Over 600 of that number have been diagnosed as having rheumatic fever. The *New York Times* recently recognized this program with a full-page story on Sunday, October 26, under the caption "Michigan Program is Hailed as Curb on Rheumatic Fever. New Long Range Fight on No. 1 Child-Killer is Cited as Example for Other States."



IT WASN'T FUN BUT IT HELPED

Ten-year-old Rosalie jokes with the nurses in the Rheumatic Fever Center at Grand Rapids. A nurse is taking blood for a test, and the other nurse and secretary of the Center assist the child. Of course, there are other tests, too—sedimentation rate, hemoglobin determination, urinalysis, x-rays, electrocardiograph. Thanks to Easter Seals.

Although officially only two years old, this program has already received $27,000 from the Easter Seal society.

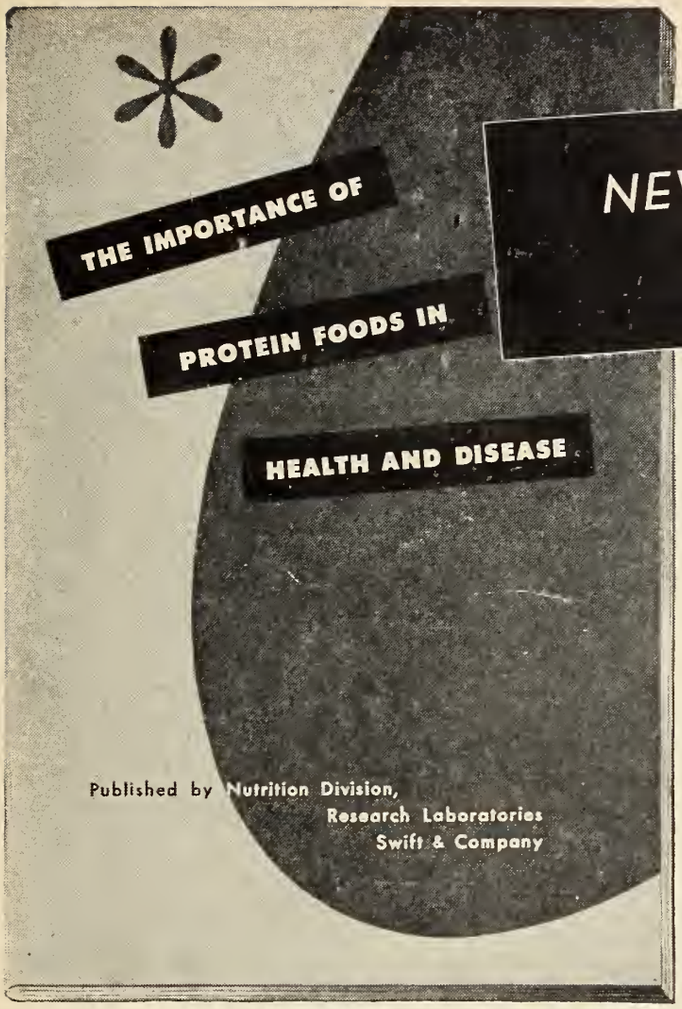
Easter Seals Support Cerebral Palsy Clinics

During the past year, the Easter Seal society has conducted six cerebral palsy clinics. Already 140 children have been examined, prescribed for, and referred to their family doctor of medicine for treatment. Five more clinics are scheduled, to date, for 1948.

Easter Seals Provide Occupational Therapy and Craft Work for the Home-Bound

For the so-called "forgotten cripple" who is home-bound, a program of occupational therapy and craft work has been inaugurated by the Easter Seal society. A staff of registered occu-

(Continued on Page 146)



NEW... physician's handbook of protein-feeding

"The Importance of Protein Foods in Health and Disease"

Free — let us send you a copy now

Written by a practicing physician, in conjunction with the Nutrition Division of Swift & Company, this booklet provides a convenient source of reference for all the important, new, published findings concerning the value of protein in the human diet.

The booklet is broad in its scope, covering the subject from *the general significance of protein in nutrition* to specific *clinical aspects*. In addition, high-caloric, high-protein diets—for both oral and tube-feeding—are included. "The Importance of Protein Foods in Health and Disease" provides a practical, working handbook of protein feeding. Let us send you your copy now. Simply write Swift & Company, Dept. S.M.B., Chicago 9, Illinois.

Also Swift's Diced Meats . . . where textures of foods indicated may be less fine, you may find these tender, juicy cubes of meat desirable.





ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

Palatable answer to many problems of protein supplementation

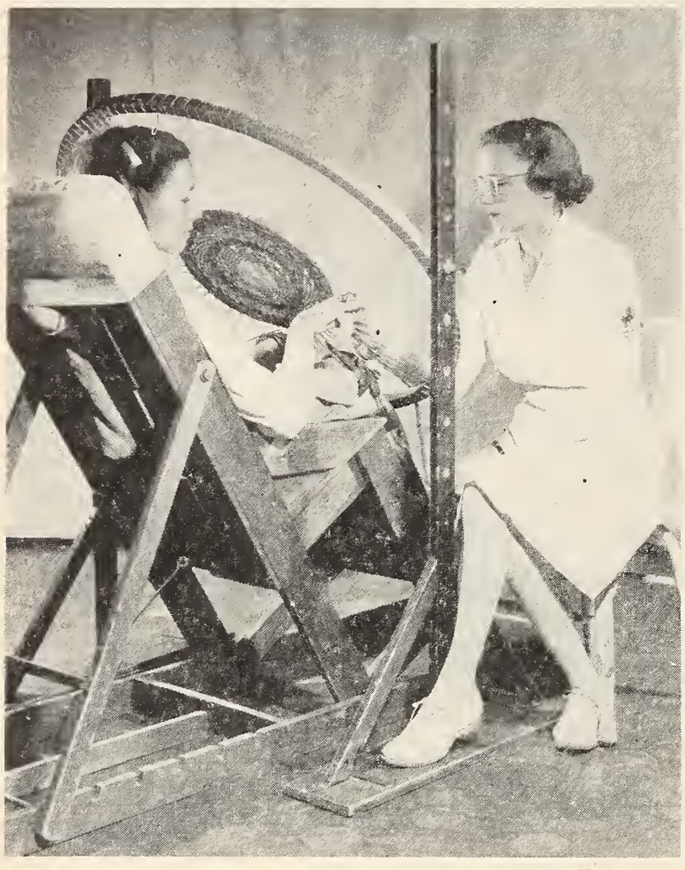
The new Swift's Strained Meats are being used more and more in soft diets where a high-protein intake is indicated. The six kinds of Swift's Strained Meats—beef, lamb, pork, veal, liver and heart—provide an exceptionally palatable source of *complete, high-quality proteins*, B vitamins and iron. Developed originally for infants, Swift's Strained Meats are 100% meat, soft and fine in texture—easily adaptable to tube-feeding.

The booklet "The Importance of Protein Foods in Health and Disease" is accompanied by a supplementary pamphlet containing simplified high-protein diets, for both oral and tube-feeding, using Swift's Strained Meats. Send for your copy today.

SWIFT & COMPANY
Chicago 9, Illinois

(Continued from Page 144)

pational therapists rotate their services across the State. The services involve interviewing, functional therapy, teaching crafts, purchasing and delivering supplies and equipment, pricing and marketing products, and returning the profits to the patients. Over 800 cases have been interviewed, 500 are now being served and have progressed to the point where they are members of the Society's Home Crafters Guild.



CRAFT WORK FOR THE HOME-BOUND

First, look at the unusual chair with wheel frame especially made for Mary. Of course, you cannot see the crippled legs, but note her crippled hands. You know what the skilled services of the occupational therapist means to her. Buy and use Easter Seals.

Easter Seals Aid the Epileptic

To serve a portion of the 20,000 epileptics in Michigan suffering from convulsive disorders, the establishment of a Center in Detroit where expert medical and laboratory techniques will be available is planned. The main function of the Center will be to aid individuals and agencies concerned with the epileptics through proper understanding, treatment, training and both social and economic adjustment. The Council of the Wayne County Medical Society has given its approval to these plans and a committee of that society will advise regarding medical practices and policies.

Easter Seals Provide Other Services

Nor are the services of the Easter Seal society limited to the above programs. In addition it attempts to:

- improve existing facilities for the care of crippled children and raise standards throughout the state through the perfection of legislation and general promotion
- assist in arranging for and help in conducting public clinics, and in individual cases see that expert medical attendance is afforded
- provide for transportation to and from hospitals and schools
- furnish wheel chairs, braces, artificial limbs and other appliances designed for the best physical development and comfort
- provide recreational activities and summer camps
- provide home tutoring for those unable to attend school and assist in the matter of convalescent care
- fill local needs for such services as special teachers, occupational therapists and physical therapists through its Special Training Grant policy.

Distinguishing Characteristics of the Michigan Society for Crippled Children and Disabled Adults

Organized in 1919, the Easter Seal society works co-operatively with state tax supported agencies as a voluntary organization to assure the physical, educational, social and economic adjustment of the cripple. As a symbol it represents the people's desire for a total and adequate care program for crippled children and adults. The Society does not render assistance that can be obtained from any other source, but it does help in the functioning of all activities in its field. Easter Seal society services are carried out on a high ethical and professional plane.

Buy and Sell Easter Seals

The investment to restore cripples to productive capacity is one society can well afford. The purchase of Easter Seals assures that this investment will be made and properly administered.

(Continued on Page 198)

In behalf of the medical profession

. . . the message reproduced below will appear in LIFE and other national magazines, reaching more than 23 million people.

A reproduction in full color will be sent on request.
Write Parke, Davis & Company, Detroit 32, Michigan.

Some things you should know about the common cold

No. 209 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



MOST PEOPLE in the United States and Canada have two or more colds a year, each lasting about two weeks and causing a considerable amount of stuffy discomfort.

The danger of the common cold lies mainly in the other infections that may follow after it. For a cold lessens your resistance, and is likely to pave the way for other, more serious, respiratory ailments.

Sinusitus, ear infections, bronchitis, and the various forms of pneumonia are frequently ushered in by a cold. Pneumonia, particularly, is likely to attack a person who is overtired, or run-down because of a severe cold.

True, many of these respiratory diseases are not as dangerous as they used to be. (Modern infection-fighting drugs—such as penicillin and the sulpha drugs—offer highly effective treatment for many cases.)

But, of course, it is always better to *prevent* a serious illness whenever possible.

If you have a cold, it's just good sense to stay away from people, to avoid spreading the infection; and to get plenty of rest—in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness.

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever.

SEE YOUR DOCTOR. Never try the foolhardy experiment of dosing yourself. Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

Let your doctor diagnose your ailments. Let him decide what treatment is best for your particular case. Then follow his instructions to the letter. His advice is the only advice you should take on any question that concerns your health.

Makers of medicines prescribed by physicians

PARKE, DAVIS & CO.

Research and Manufacturing Laboratories, Detroit 32, Mich.

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You and Your Business

AMERICAN ACADEMY OF GENERAL PRACTICE

Members in forty-two states, the District of Columbia and Hawaii have been enrolled in the newly formed American Academy of General Practice, according to a statement issued by Dr. Paul A. Davis, Akron, Ohio, president of the Academy. Applications are being received at the rate of nearly 100 a week at the headquarters of the national association of general practitioners of medicine and surgery, temporarily located at 20 North Wacker Drive, Chicago 6, Illinois. Mac F. Cahal, executive secretary of the American College of Radiology, is serving as general counsel and acting executive secretary of the Academy of General Practice.

Doctor Davis, president, was last year chairman of the Section on General Practice of the American Medical Association. Other officers of the Academy are: Dr. E. C. Texter, Detroit, vice president; Dr. U. R. Bryner, Salt Lake City, treasurer; Dr. Stanley R. Truman, Oakland, California, secretary.

The American Academy of General Practice was founded June 10, 1947, in Atlantic City, by a group of men who believed that organized effort would best assure the preservation of the general practitioner as the foundation stone of the finest medical system the world has ever known. Numerous small groups of general practitioners throughout the country had organized, but general practice on a national scale had no voice. Therefore, the members and officers of the Section of General Practice of the American Medical Association, meeting out of official session at the San Francisco meeting in 1946, set in motion the machinery that culminated in the founding of the American Academy of General Practice at the 1947 convention at Atlantic City and into which all local groups have been united.

The Academy has no official connection with the American Medical Association except that its members must be members of the American Medical Association. The Academy plans to support and co-operate with the AMA in its high ideals and will also support every other group whose aims are unselfish and for the best interests of the public health.

The purposes of the Academy, as set forth in its constitution are:

1. To promote and maintain high standards of the general practice of medicine and surgery.
2. To encourage and assist young men and women in preparing, qualifying, and establishing themselves in general practice.
3. To preserve the right of the general practitioner to engage in medical and surgical procedures for which he is qualified by training and experience.
4. To assist in providing postgraduate study courses for general practitioners, and to encourage and assist practicing physicians in participating in such training.
5. To advance medical science and private and public health.

To be eligible for membership a physician must be engaged in general practice. He must be duly licensed in the state in which he practices, and must be of high moral and professional character. He must have had at least one year of rotating internship at an approved hospital, or the equivalent in postgraduate training. He must have been in general practice for at least three years. (Special consideration is being given by the Membership Committee to military service). He must have shown interest in continuing his medical advancement by engaging in postgraduate educational activities.

Since its inception the progress in organization has been remarkable. After only three months the membership is larger than all but the two or three largest specialty groups. By stimulating postgraduate study and establishing a standard of quality toward which all conscientious general practitioners will strive, the Academy will promote progress in general practice in much the same way the specialty societies have promoted progress among specialists.

"It seems obvious," said Mr. Cahal, "that high standards and progress among the family doctors, who render at least 85 per cent of the medical care furnished in America, is the most important single goal for the medical profession today. Through the organization of the American Academy of General Practice the means for achieving that goal has been provided."

MIDWEST REGIONAL CONFERENCE

Medical society representatives from six states participated in the Mid-West Regional Conference, sponsored by the American Medical Association on Medical Service, in Cleveland, Sunday, January 4—the day before the AMA interim session opens.

Medical societies participating were: Illinois, Indiana, Kentucky, Michigan, Ohio, and West Virginia.

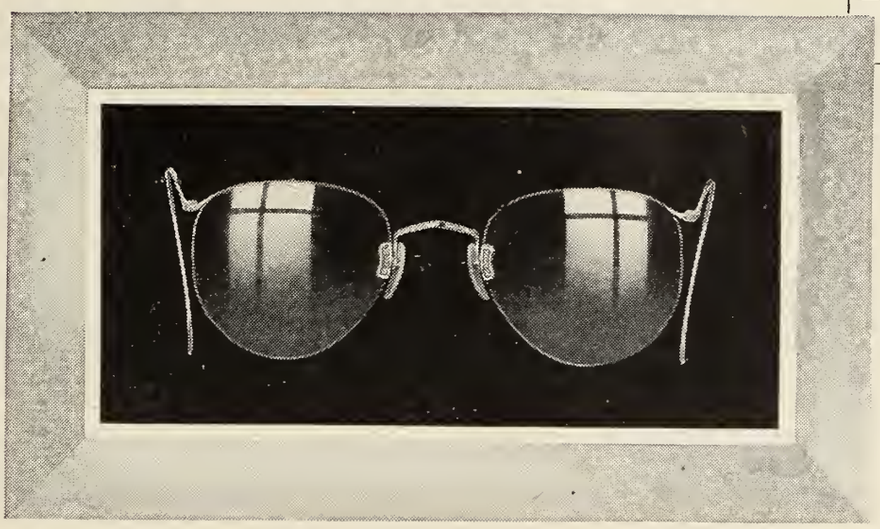
Roundtable discussions keynoted the program. The morning roundtable, "Exploring for Services," was devoted to a discussion of services the AMA can render medical societies. In the afternoon, a roundtable was held on "Modern Medical Public Relations."

The speaker at the luncheon in the Hotel Cleveland was R. R. Sayers, M.D., Washington, D. C., Chairman, Medical Advisory Board, United Mine Workers of America, Welfare and Retirement Fund.

The committee on arrangements was Harold M. Camp, M.D., Monmouth, Ill.; Ray E. Smith, Indianapolis; Charles Lively, Charleston, West Virginia; P. E. Blackerby, M.D., Louisville, Ky.; William J. Burns, Lansing, Mich., and Charles S. Nelson, Columbus, Ohio.

Speakers at the morning roundtable were all from the AMA organization and each told of the services available from the various Bureaus and Councils. They were: W. W. Bauer, M.D.; Thomas G. Hull, Ph.D.;

(Continued on Page 152)



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EYE-PHYSICIANS KNOW.....THAT GLASSES MADE FOR their patients *satisfy*, or they *do not satisfy*, and there *can't* be half-way mark between.....

DOCTOR . . . when you place new "glasses" gently, anxiously, hopefully over your patient's temples . . . and adjust them skillfully to make them comfortable . . . . .

. . . . . or, when *we* do that for you in *our* fitting rooms . . . . .

. . . . . all *your* hours and days of careful preparation, all your years of study and preparation and *all of your reputation* are at stake . . . . .

Those glasses fit comfortably, the patient sees satisfyingly, he likes the smart appearance of the mounting . . . . and your work is done and patient dismissed . . . . .

. . . . to tell his (or her) world how "*skillful*" you are, how "*smart*", how "*dependable*" . . . and "*you ought to go to him* if you want the *finest*, in *modern* glasses."

OR . . that patient *never* returns, *never* speaks generously of your skills . . . . and your progress is retarded.

Thus, *all* of your future, all of your income and all of your fame hangs precariously on the satisfied acceptance (by your patients) of *your prescriptions* . . . . that *someone else* fills or fabricates for you and them.

Lean on us at Uhlemann's!

Know that *all* of the prescriptions of yours (that come to us) will be fabricated meticulously, with skills and intent that we believe incomparable . . . . that *your* fame may grow, satisfyingly.

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DAYTON ✦ KANKAKEE

ESTABLISHED 1907

Say you saw it in the Journal of the Michigan State Medical Society

MIDWEST REGIONAL CONFERENCE

(Continued from Page 150)

J. W. Halloway, Jr., LL.B.; Ralph Creer, A. W. Adson, M.D. The afternoon session speakers were:

"Inventory"—Lester H. Perry, Executive Secretary, Medical Society of the State of Pennsylvania, Harrisburg, Pennsylvania.

"Pay Dirt"—Hugh W. Brenneman, Public Relations Counsel, Michigan State Medical Society, Lansing, Michigan. "Horizons"—George H. Saville, Director of Public Relations, Ohio State Medical Association, Columbus, Ohio.

One of the speakers, giving an address of welcome, C. W. Wyckoff, M.D., president of the Cleveland Academy of Medicine, made a strong plea for changes in the requirements of the specialty boards to require five years of general practice before a candidate is eligible to take the examination for certification. He cautioned against the "early specialization of immature doctors."

Gleanings of the conference: "Any organization is only as strong as the interests of its members." "Government officials are very circumspect in their 'work-shop' contacts since the Harness Committee report." "Entertainment expenses in connection with, or for the extension of business are a deductible charge in computing income tax according to a recent decision." "Articles in the *Reader's Digest* which are biased do more harm in influencing public opinion than all the good works of hundreds of well-intentioned and well-behaved doctors." "Tabulations show that over 82 millions of persons in the United States are now subscribing for some form of accident and health insurance, or prepaid medical services."

GOVERNORS HOLD REGIONAL CONFERENCE

Governors Thomas E. Dewey, of New York; Alfred E. Driscoll, of New Jersey; and James L. McConaugh, of Connecticut; met December 18, 1947, at the Roosevelt Hotel, to exchange views on the possibility of eliminating duplication of taxing fields by the Federal and state governments, adding sickness compensation to the social security structure and increasing unemployment insurance and workmen's compensation benefits. No attempt was made to arrive at final conclusions, but the subject matters may be material for future legislative enactments. Last year Governor Driscoll had urged a sickness compensation program, but failed to get legislative approval. A similar program was urged by the State Federation of Labor, in New York state, but failed in the legislature.

THE TIME IS LATER THAN YOU THINK!

The Washington Post of December 26, 1947, carries the following story:

"TAFT READY TO MAKE ISSUE OF HEALTH BILL

"Senator Taft (R., Ohio) yesterday challenged Democrats to make an issue of compulsory health insurance in 1948, declaring that he will seek Congressional approval for an alternative plan for Government grants to states for medical care.

"The Ohio Senator told a reporter he has noted increasing propaganda activity in behalf of the long beleagured Murray-Wagner-Dingell Health Insurance bill, adding that he expects Democrats to push strongly for its passage in the session beginning January 6.

" 'It's all right with me if the Democrats want to make an issue of it,' said the Ohio Senator. 'I don't think the people of this country want the regimentation involved in a compulsory plan that makes every doctor subject to Government regulation.'

"Taft says he expects President Truman to renew in his State of the Union Message to Congress the appeals he has made in the past for health insurance legislation.

"Democrats to Push Measure

"Senator Murray (D., Mont.), one of the authors of the Murray-Wagner-Dingell measure, said Democrats will make 'every effort' to bring it up next session.

"He said that some changes in its form will be considered, adding that a recent suggestion by Bernard M. Baruch, adviser to Presidents, that the compulsory features of the law be confined to persons with incomes of less than $5,000 a year will be studied.

"Although the coming session of Congress will be devoted largely to debate over European recovery and anti-inflation measures, Taft indicated that he hopes to win approval of certain other measures.

"He mentioned, in this connection, pending legislation for State grants to States to help finance education, a program of increasing veterans housing and his own medical care bill.

"The latter measure is designed to provide medical and hospital care on a State basis, through voluntary contributions, rather than through a system of compulsory health insurance.

"Convention a Factor

"It was the announced intention of the Senate's Republican leadership at the close of this year's regular session of Congress to devote much of the new session to this type of proposal.

"But with the European Recovery Program and proposals to curb the cost of living, plus the necessity of acting on regular appropriations bills, may leave little time for other legislation if the GOP leaders end the session before their party's scheduled June 21 presidential nominating convention in Philadelphia.

"Taft said he will call the Senate Republican Policy Committee together shortly after Congress convenes January 6 to map a program. Chairman Vandenberg (R., Mich.) of the Senate Foreign Relations Committee already has served notice he wants early consideration of the House-approved Mundt Bill authorizing a foreign information program and of legislation approving the St. Lawrence seaway agreement with Canada."

middle age + *a "sense of well-being"*

A gratifying "sense of well-being" is the experience most often reported to clinical investigators by menopausal patients receiving ***"Premarin."*** *This is the "plus" usually afforded by this naturally occurring, orally active estrogen.*

Flexibility of dosage for adaptation of oral estrogenic therapy to the particular needs of the patient is possible with the three potencies of ***"Premarin."***

Tablets are available in 2.5 mg., 1.25 mg. and 0.625 mg.; also liquid containing 0.625 mg. in each 4 cc. (1 teaspoonful).

While sodium estrone sulfate is the principal estrogen in ***"Premarin,"*** *other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are probably also present in varying amounts as water soluble conjugates.*

CONJUGATED ESTROGENS (equine)

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Editorial Opinion

CASE OF A VANISHING DOCTOR

The suggestion of Surgeon General Parran that a system of awarding federal scholarships to medical students be established, in order to insure that future government needs for physicians will be met, serves to dramatize the shortage of doctors that is in some areas of the nation already acute. Dr. Parran estimates that by 1960 the country will need between 50,000 and 55,000 more doctors than are now in prospect.

The lack of general practitioners in rural America presents one of the most serious problems of contemporary medicine. The country doctor has been going down the last lanes of a career that made him a beloved memory, ever since the twentieth century turned the corner of the century on two wheels of the newly arrived automobile. He knew the relationship between the ills of the body and the mind before the arrival of psychosomatic medicine. Besides being a discerning psychosomatist, he was obstetrician, dentist and pharmacist. For decades now the trend has been toward specialization in medicine, and towards the practice of group medicine in clinics.

The progressive shortage of medical personnel in all categories will add to the seriousness of the problems of public health and medical care in the small towns and the American countryside as time goes on. To provide federal scholarships for medical students on a wide geographical basis, upon the agreement of the candidates to serve a stipulated time in one of the federal services, approaches the problem from one important aspect—the rising costs of medical education. Yet medical educators may look askance at the proposal of Dr. Parran that candidates for medical scholarships might be nominated by Congressmen and Senators in the same manner that appointments to the United States Military Academy at West Point and the Naval Academy at Annapolis are made. There is little parallelism between military and medical education. The Government controls and directs education at its military and naval schools, but medical educators want a maximum of freedom, and no hint of political directions.

The crux of our national problem of medical care is the case of the vanishing general practitioner. The plot is to rediscover him and put him back in the countryside. He must have small hospitals and medical centers in which he can practice medicine with the clinical and laboratory facilities modern medical education teaches him to use. These facilities should have a connection with medical schools and urban medical centers to give the modern general practitioner the professional stimulus he needs.

With the passage of the Hill-Burton Act, Congress approved a program which provides for federal grants of one-third the initial construction costs of hospital and medical care facilities, with priorities being given to areas where the need is greatest. Here is a base for a highway to medical care along which we may rediscover the country doctor.—Editorial in *New York Times*, December 14, 1947.

NICE WORK IF YOU CAN GET IT

Directors of Detroit Hospitals have been negotiating for the services of trained anesthesiologists and some interesting things have come to light. Of three men interviewed the salary demands ranged from $1,000.00 to $1,500.00 per month. In addition each stipulated the right to give two private anesthetics a day at a minimum fee of $25.00 per. One wanted in further addition a fee for all anesthetics given by the nurse anaesthetists in industrial and insurance cases. Furthermore while they would supervise the work of the nurse anaesthetists, they would not teach in a school of anaesthesia in which nurses were the students.

We know of no one familiar with medical sociology and economics who isn't concerned about the growing shortage of physicians and who does not subscribe to the principle of supervised, trained medical assistants. The nurse anaesthetist, under good supervision, has done a very essential and creditable job. To arbitrarily refuse to teach anaesthesia to nurses is evidence of very disorderly thinking. The Board Member is best qualified to do that teaching and should feel it is his duty to do so and if there is a clause in the code of the Board of Anaesthesiology which prohibits members from instructing nurses it should be rescinded in the name of common sense.

We think it is obvious that it will be a very long time before there will be enough certified physician anaesthetists to give all anaesthetics. At present there are less than four hundred in the entire country and Michigan alone could more than use up that number if certified anaesthetists were made mandatory.

Now back to the fees demanded by the men referred to. Simple calculation reveals an annual salary of from $20,000.00 to $35,000.00, plus. It should be noted that these men have had no long experience in their field nor have they made any vital contribution to the advancement of medicine. One had not yet completed a three-year residency in anaesthesia—the other two had so little clinical experience that they were not yet eligible to even try the examinations of the American Board of Anaesthesiology for certification.

These boys have taken a very businessy viewpoint toward medicine and are pushing the ancient weapon of supply and demand to the hilt. The grandiose figures asked is very suggestive of briefing somewhere along the line.

They are taking advantage of the panicky scramble of hospital staffs to meet the edicts of a growing central government in medicine, established and maintained by ourselves.

(Continued on Page 156)

Announcing . . .

THE OPENING OF THE FINEST AND MOST FULLY EQUIPPED SHOWROOMS IN THE STATE FOR THE SALES AND SERVICE OF

MATTERN X-RAY EQUIPMENT

BY THE

DETROIT X-RAY SALES CO.

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BETWEEN WOODWARD AND PARK

The fine patronage afforded this Company by our many friends in the Profession has necessitated enlargement of our place of business.

Our new modern building provides more adequate showroom and warehouse space.

We extend a cordial invitation to visit our up to date new showrooms where we are displaying the latest Mattern Models of X-Ray Equipment under actual working conditions. Model darkrooms and all.

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SAME TELEPHONES — TEMPLE 1-6140-41-42

FREE PARKING

NICE WORK IF YOU CAN GET IT

(Continued from Page 154)

They are supplying the most potent argument to protagonists for socialized medicine.

College students (non medics) say of the practice of medicine: "The hardest part is to get into and through a medical school. From then on it's a breeze."—Maybe they're right.—Frank A. Weiser, M.D., in *Detroit Medical News*, January 12, 1948.

OPERATION OMINOUS

Have your ear-plugs handy—the bombardment is about to resume! Every potential presidential candidate in the field has declared for some sort of public medical care plan. Every plan will be designed, more or less, toward the political regimentation of the practice of medicine.

It is not a secret that the politicians of this country are out to regiment the practice of medicine into socialism. And from socialism to totalitarism is but another step. The politician is, no doubt, in greater fear of this trend than are the doctors of medicine. He has had the tail of the tiger thrust into his hand and he fears to let go. He is afraid to ignore the cry of "Wolf!" even though he knows it is a false alarm. He needs our help.

On the same side of reason we have the fact that the year 1947 established a record all-time low in mortality and an all-time high for national health. The improvement of the public health since 1900 is nothing short of a miracle based on standards existing at the beginning of the century. Such a record is not an accident, nor is it a miracle performed by politics. It is, to the contrary, the barometer of the steady progress in the improvement of medical care wrought by a hard working medical profession under the stimulation of a system of free enterprise. It is an unanswerable rebuttal to those who seek to socialize the practice of medicine in America.

Until our federal government began to force patronage on a free and enterprising people, we always found a way to solve our problems without turning to Washington with our alms-cup in our hand. We can still work our passage if freed from the poison touch of politics. The practice of medicine with its unparalleled record for the past 47 years is to become the political football of 1948. In your tampering with medicine, Mr. Politician, you are playing with Socialism and courting Communism. Remember, as Medicine goes, so goes the Nation!—A.C.P.—Editorial, *Bulletin Genesee County Medical Society*, January 13, 1948.

Michigan Medical Service

The Doctors of Medicine Prepaid Health Plan for Michigan

Michigan Medical Service was organized in March, 1940, by the Michigan State Medical Society under a special act passed in 1939 by the Michigan State Legislature. The plan proved to be popular and rapid enrollment gains have been made since then. As of September 30, 1947, Michigan Medical Service had over 3,000 enrolled groups covering 909,120 members. This is approximately one-sixth of the population of Michigan.

Proof of the popularity of Michigan Medical Service and the Blue Cross coverage is the fact that many of the large industrial groups such as General Motors and Chrysler have enrolled in the plan. At the present time there are over 3,000 employed groups enrolled.

Enrollment of new groups is rather strictly controlled. To qualify as a group, an organization must employ five or more people. In an organization of five people, all must enroll for the group to be acceptable. In an organization of six to eleven people, all but one must enroll. At least ten must enroll in groups of twelve or thirteen people. In large groups, 75 per cent enrollment of the employees is required before the group is acceptable.

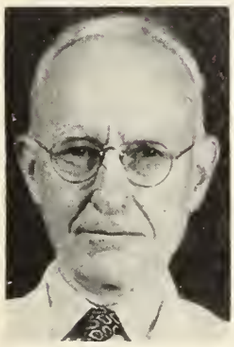
Re-enrollment is conducted annually in groups of 100 employees or less, semiannually if the group is larger. A recent regulation requires that at re-enrollment time no new applications will be accepted unless there are enough applications to bring enrollment up to 75 per cent or better. When re-enrollment does not result in 75 per cent participation, new applications will be acceptable if the new applications bring total enrollment up to 65 per cent and at least 20 per cent of these not enrolled apply.

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The Early Diagnosis of Pancreatic and Ampullary Growths

An Evaluation of their Surgical Treatment

By Allen O. Whipple, M.D.
New York



THERE ARE certain factors characteristic of pancreatic and ampullary tumors which determine their diagnosis, treatment and prognosis: (1) The great majority of these growths are carcinomas. (2) The site of the tumors varies but determines (a) their malignancy rate, (b) their early clinical symptoms, (c) their laboratory findings, (d) their operability, and (e) their prognosis.

The carcinomas of the ampulla are usually of the papillary or fungating type, are less malignant, give early signs of obstruction, but because of a tendency to ulcerate, produce at times a misleading intermittent jaundice. The carcinomas of the terminal common duct cause an early progressive jaundice, but produce a late decrease, or no decrease at all, in the flow of pancreatic juice. The carcinomas of the pancreas give symptoms and signs, early or late, depending upon the part of the pancreas involved. The presence of jaundice and the time of its appearance depend upon the initial site of the tumor—in the head, body, or tail of the pancreas.

Because of the proximity of the ampullar area to other parts of the upper gastrointestinal tract and the similarity of many of the symptoms common to both areas, cancers of the ampulla and of the head of the pancreas and the common duct are frequently confused with benign or functional disturbances of the stomach, duodenum and biliary tract. If a gastrointestinal series is negative in a patient complaining of indigestion and loss of weight, the diagnosis of gastric neurosis is too often made. Yet the lesion may be a carcinoma of the head or body of the pancreas. If the patient is jaundiced and has epigastric pain, the diagnosis of gallstones is made, a low fat diet is prescribed, and a conservative regime is followed for weeks or months in the hope that the jaundice will clear. Further differential diagnostic tests, to determine the presence of a malignant lesion in the ampullar area, are seldom carried out, and the patient is not referred to the surgeon until the lesion has become irremovable.

Diagnosis

Clinical History.—Pain, jaundice and digestive disturbances depend largely on the site of the growth (Fig. 1). If the growth is at the ampulla (Site 1), pain is usually absent but jaundice appears early with acholic stools; the presence of red blood cells and the absence of bile and pancreatic ferments in the duodenal aspiration studies are characteristic. If the carcinoma ulcerates, there may be a temporary remission of jaundice. If the growth is in the head of the pancreas (Sites 2 and 3), pain is usually present, often radiating to the back, and may be of a severe boring type. Jaundice may appear early if the growth is near the common duct (Site 2), but if in the lower

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end of the head (Site 3), it will be a late sign. Pancreatic ferments are usually diminished or absent, according to the site of the growth in blocking the main pancreatic duct. Fat indigestion

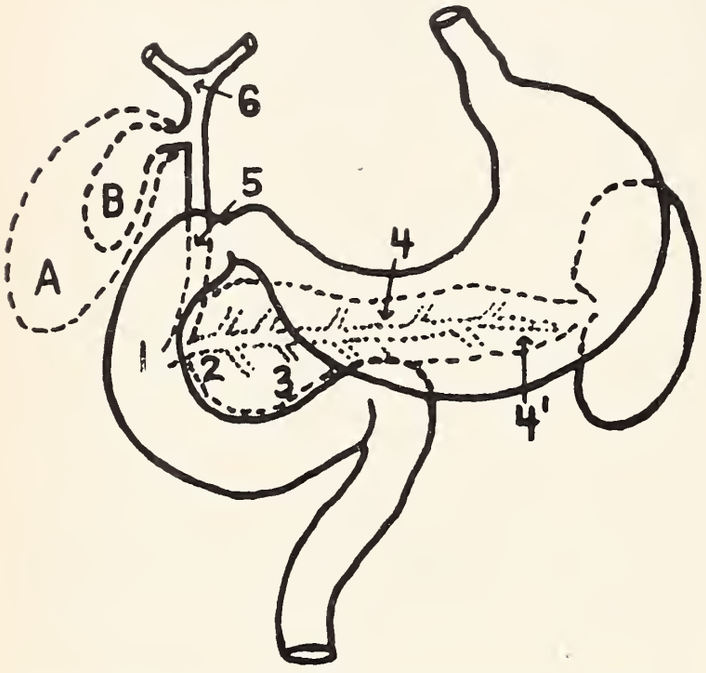


Fig. 1. Diagram to show sites of malignancy in the ampulla, pancreas and common duct.
(1) Ampulla. (2 and 3) Head of the pancreas. (4) Body and tail of the pancreas. (5) Common duct. (6) Common hepatic duct.
(A) Distended gall bladder, found with growths at Sites 1 and 5.
(B) Collapsed gall bladder, found with growth at Site 6.

and loss of appetite with early weight loss is usual. With the growth in the body and tail (Sites 4 and 4′), fortunately a rare site, the diagnosis is much more difficult. Jaundice is absent. Pain, however, may be severe, radiating to the back. Asthenia and loss of appetite and weight are marked. Ptyalism may be present. Laboratory tests are not informative. Severe epigastric pain, radiating to the back, with negative laboratory tests, points to a carcinoma of the body or tail of the pancreas. With a carcinoma of the common duct below the hepatic duct (Site 5), jaundice appears gradually but progressively and without pain. Duodenal studies show little or no bile but normal pancreatic ferments. X-ray studies or cholecystography are not informative. With the growth in the hepatic duct above the cystic duct (Site 6) the symptoms are the same as in Site 5. The difference between these two sites is that in Site 5 the gall bladder is usually enlarged (Fig. 1, A), and in Site 6 it is collapsed (Fig. 1, B). Almost invariably with the appearance of jaundice, itching of the skin is a prominent symptom. It may be so severe as to dominate all other complaints and warrants a sidetracking operation, if only as a palliative procedure.

Physical Signs

In Sites 1 and 5, with jaundice, the gall bladder is enlarged (Fig. 1, A), fulfilling Courvoisier's Law, unless there has been an antecedent chronic cholecystitis with gallstones. In Site 6 the gall bladder is not enlarged or palpable (Fig. 1, B). In all of these lesions, with jaundice, the liver is usually somewhat enlarged, and if markedly so, it may override the gall bladder even when the latter is distended. Jaundice, as a physical sign, may or may not be present, according to the site of the lesion. A tumor mass may be palpable, but this is the exception, and failure to feel a mass in no way rules out a malignant tumor.

Laboratory Tests

Blood Studies.—A rising serum bilirubin accompanies increasing jaundice, as does the alkaline serum phosphatase, in all cases of extrahepatic obstruction. Blood amylase studies are not informative in chronic lesions of the pancreas.

Duodenal Intubation Studies.—These should be done with the double tube, one in the stomach to aspirate gastric contents, the other in the duodenum for aspirating bile and pancreatic juice. With the tube in place, the gastric juice is first aspirated, then the duodenal bile is aspirated, then mecholyl is given hypodermically for vagus stimulation of concentrated pancreatic juice. This should be aspirated into ice-cold test tubes for biological assay. The techniques for this procedure have been clearly described by Dr. L. Bauman in the *American Journal of the Medical Sciences,* 207:281, 1944. Both the bile and pancreatic juice should be sampled for red cells. Their presence is significant and indicates an ulcerating carcinoma.

X-ray studies of the duodenum, following the swallowing of barium, may show a deformity of the duodenum or a filling defect. A positive finding is significant. A negative fluoroscopic examination and a negative film do not rule out a tumor. The presence of calcareous shadows in the flat film of the upper abdomen points to a chronic pancreatitis or a cyst, rather than to a neoplasm.

Treatment

It must be clearly appreciated that the malignant lesions of this area result invariably in death,

if untreated, in a period of six to eight months. Surgery, either radical or palliative, offers the only relief. Chronic inflammatory lesions of the pancreas may give symptoms entirely indistinguishable from the malignant tumors, and even at the operating table they may not be differentiated. For this reason, an early diagnosis while the lesion is small, confined to one of the sites mentioned, and before lymphatic, vascular and contiguous spread has occurred, determines the operability and prognosis. For this reason, patients with suggestive symptoms and definite findings should be operated upon early, and not studied to death.

The radical surgery that is now being carried out in these lesions is only of some ten years' duration, for before 1935 such lesions were considered incurable and any surgery that was done was purely of a palliative nature. But five factors have made possible the removal of the head of the pancreas, the entire duodenum, the pylorus and the terminal common duct, as well as total pancreatectomy:

1. Preoperative, operative, and postoperative transfusion.
2. Maintenance of protein, salt and fluid balance and appreciation of its importance.
3. Chemotherapy in preventing or combatting infection.
4. Advances in surgical technique, with the use of so-called silk technique and the use of finer instruments that go with it.
5. The use of Vitamin K.

By the use of these advances the long and careful operations necessary in these radical procedures, can now be done. The clock is no longer the measure of a surgeon's ability.

Palliative Procedures

In the majority of patients with the lesions described, a radical excision of the growth is not feasible at present because of the delay in sending these patients to the surgeon. In the majority of these delayed cases, jaundice with severe pruritus and impaired fat digestion are dominant symptoms. These unfortunates can be made more comfortable for a period of weeks or months by a short-circuiting operation between the gall bladder and the duodenum or jejunum. The stomach should not be used because of the greater danger of a cholecystitis and cholangitis.

The Results of Radical Surgery

No attempt is made in this presentation to give the techniques and the details of the radical operations. Many modifications of the one-stage or two-stage procedures have been described; the procedure should be made to fit the patient, not the patient to fit any one modification.

From many surgical clinics individual cases have been reported. But in four clinics especially, a fairly large number of these radical operations have been done: forty-nine at the Mayo Clinic, twenty-seven at the Billings Hospital, Chicago, forty at the Columbia-Presbyterian Clinic, and forty-nine at the Lahey Clinic—165 cases at the last reports from these centers. These figures include fourteen total pancreatectomies, not all for carcinoma. The over-all postoperative mortality is still high, some 30.8 per cent, but this includes all the early reported cases, and the operative risk has been steadily reduced in the last five years.

Dr. Waugh, from the Mayo Clinic, reports nine patients living, one year to three years after operation, with an average of two years. Dr. Brunschwig, from Chicago, reports six patients living, from one to four years, the longest four years, and back to normal activities. The series at the Presbyterian Hospital shows six patients living from six months to six years. The latter patient had the first one-stage radical operation reported by the writer. She had a carcinoma of islet cells in the head of the pancreas without symptoms of hypoglycemia. Unfortunately, at the present time, although as active as ever, this patient shows evidence of liver nodules.

Dr. Catell, of the Lahey Clinic, has had forty-nine resections with only eight postoperative deaths (16.3 per cent), a very remarkable record. Half of these patients had carcinoma of the ampulla, and the rest had carcinoma in the pancreas, except for two carcinomas in the duodenum and two of the common duct. Forty-two per cent are living; one patient has lived sixty-two months, several over three to four years. Two thirds of the operations were in two stages, the other third in one stage.

At best, the results are not brilliant, but some of these patients are given a life activity and expectancy that they could not otherwise have. As patients are diagnosed earlier and as the techniques for the radical operations improve, the immediate and late mortality should show real improvement.

Carcinoma of the Rectum and Lower Part of the Sigmoid Flexure

Present-Day Management

By Claude F. Dixon, M.D.
Rochester, Minnesota



THE SIGMOID flexure of the colon is, on the average, 40 cm. long, and the rectum is approximately 12 cm. long. The two structures, then, together have a length of approximately 52 cm. or about 20½ inches, which certainly does not seem impressive in comparison with the total length of the large intestine, which is about 150 cm. or 59 inches. Yet, it is a fact that carcinomas which occur in these 20½ inches of the intestinal tube often constitute a more baffling therapeutic problem than do carcinomas situated anywhere else in the large intestine. The reason for this is the complexity of the therapeutic and physiologic factors involved, as well as the relatively small portions of tissue with which the surgeon is able to work. That is, the lesion itself must be removed adequately, yet, despite, the resultant loss of the involved part of the tube, provision must be made for the exitus of the fecal stream. The result is that when a distal segment is the site of a carcinoma, an artificial anus or colonic stoma often must be created.

In many instances, psychic as well as physiologic considerations tend to make the establishment of such a stoma a formidable problem for the patient to face, and hence, a difficult decision for the surgeon to make. On the other hand, the surgeon as well as the patient some times is amazed at the remarkable ease and comparative comfort with which many patients who have colonic stomas are able to maintain themselves.

There can be no question of the fact that preservation of the continuity of the bowel after excision of a malignant process is most desirable, but it is not always possible. In the present communication I purpose to consider, so far as limitations of space permit, those therapeutic procedures for carcinoma of the rectum and lower part of the sigmoid flexure which I have found to be most feasible and most productive of satisfaction for the patient.

Read at the eighty-second annual session of the Michigan State Medical Society, at Grand Rapids, Michigan, September 24, 1947.
Dr. Dixon is from the Divison of Surgery of the Mayo Clinic.

Carcinoma of the Rectum

Local Excision.—It is an unfortunate fact that local excision of malignant neoplasms of the rectum can be accomplished with safety in only a very few instances. This cannot be emphasized too strongly.

When a carcinoma is localized to the rectum proper, and when this lesion does not involve more than the mucosa and submucosa, it may be possible adequately to excise the neoplasm without prolonged interference with functional activity. In certain cases the surgeon must completely divide the anal sphincter muscles in order to achieve exposure which will be sufficient for excision of the lesion.

Even so, it remains true that most malignant processes of the rectum attain to such size and extent before they are recognized that local excision becomes impossible. Hence, at present it is still valid to point out that, in most cases, carcinoma of the rectum necessitates some form of radical surgical operation.

Radical Surgical Treatment.—For a while, Hochenegg's so-called pull-through operation seemed to offer great hope in the surgical treatment of carcinoma of the rectum. In this procedure, which dates from 1888, the initial approach is abdominal, so that the pelvic colon can be freed. Next, the perineal approach is employed, so that either the carcinous segment of the rectum or the entire rectum can be excised. Finally, the normal distal end of the freed sigmoid colon is pulled through the anal sphincter muscles and anchored.

I think there are at least two reasonable objections to Hochenegg's operation. First, serious interference with the nerve supply of the internal anal sphincter may be brought about by the operation, which means that involuntary control of the bowel would be abolished. Second, the Hochenegg operation does not allow radical excision of the perirectal tissue. Such excision is now considered to be important, because the perirectal tissue often has been found to be the site of secondary spread of the malignant process.

It appears that currently Hochenegg's operation, which is utilized by Babcock, Bacon and others, is again being accorded rather extensive favor. Yet, so far as I have been able to judge from my own experience, the procedure has only limited application. Like the local excision which I mentioned, the Hochenegg operation probably ought to be used only for small, localized carcinomas of the rectum.

The Miles combined abdominoperineal operation and the Kraske or Lockhart-Mummery procedure constitute methods for more radical excision of carcinomas of the rectum. In the Miles operation a permanent single-barrel abdominal colonic stoma is created; in the Kraske or Lockhart-Mummery operation a permanent loop type or double-barrel colonic stoma is established and is followed by resection of the rectum by the perineal approach. Such resection as a rule is a secondary operation, carried out ten to fourteen days after the primary procedure.

My own view is that the Miles abdominoperineal operation, carried out in a single stage, may not adequately satisfy the needs for which it was designed. That is, the extent of radical excision of tissues, as between the abdomen and rectum, is not equitable, as this operation generally is performed. The surgeon who carries out the operation usually recognizes and even emphasizes the importance of radical excision so far as the abdominal aspects of the technique are concerned, but at the perineal or final stage of the operation he does not radically excise the perirectal tissues which so frequently are the sites of direct extension of the process or spread of it by lymphatic pathways. Miles, when he first reported his procedure, declared that carcinoma of the rectum rarely if ever spread laterally, but this is a statement that has not been substantiated.

It is incontestable that the combined abdominoperineal operation has often effected permanent relief of carcinoma of the rectum. But it is also true that some patients who underwent this operation, and were expected to be permanently relieved thereby, have had to seek additional treatment because of recurrence of the malignant process in the perineum. Explanations of such recurrences are varied; I think that in part, at least, they are caused by remaining malignant tissue or carcinous lymph nodes which in some instances could have been eradicated if the perirectal fat, fascia propria and levator ani muscles had been more widely excised at the time of operation.

I do, however, perform a combined abdominoperineal operation for carcinoma of the rectum, but I carry it out in two stages. This permits much more radical excision of questionable tissues than otherwise would be possible; I think it is also less productive of shock, especially among patients sixty-five years old or more, than is the one-stage operation. Hence, it is reasonable to assume that the morbidity and mortality rates associated with the procedure are lowered appreciably. The technique which I employ follows:

At the initial procedure, the abdominal cavity is approached by means of a low rectus incision. The colon is divided between two Payr clamps at a site near the level of the sacral promontory. The sigmoidal mesentery, including the superior hemorrhoidal vessels, is divided and ligated. The posterior parietal peritoneum is incised only at the base of the mesentery, where the superior hemorrhoidal vessels are clamped, divided and ligated. The left ureter also is identified and isolated. Next, the proximal end of the distal sigmoid is inverted and the segment of bowel is dropped free into the pelvis. The small defect in the posterior parietal peritoneum is repaired by the placing of two or three interrupted catgut sutures. Finally, the distal end of the descending colon is brought through the primary incision or through a small muscle-splitting incision in the left iliac region, so that a single-barrel stoma is created. In the performance of colostomy the anterior peritoneum never is sutured to the bowel, which is held in place by means of a Payr clamp.

On the day after the operation, the colon is opened by means of cautery, immediately beneath the clamp. The clamp automatically becomes detached on the fifth or sixth postoperative day. After a period of ten to fourteen days, the colonic stoma is functioning satisfactorily. Such patients are out of bed on or about the fifth postoperative day.

The second and final or perineal stage of the operation is carried out with the patient under the influence of low spinal or sacral anesthesia produced by 100 to 120 mg. of procaine hydrochloride. The patient is placed in a reverse Trendelenburg position, and the distal segment of bowel, which includes the rectum and sigmoid flexure of the colon, is removed. A fluid ounce

(30 c.c.) of merthiolate is instilled through the anus. Swabbing of the anorectal tissues must not be done, since this maneuver might force some of the malignant cells from the rectal neoplasm into the lymphatic or circulatory system. Furthermore, swabbing might cause certain types of bacteria which occur in the lesion secondarily to be dislodged into the same channels, producing such serious or fatal infectious processes as species of Bacteroides cause, a complication that I have emphasized in previous publications. Next, the anus is closed by means of a purse-string type of suture. Then, with the cautery, an incision is made; this incision begins at the level of the base of the coccyx and extends about 3 inches (8 cm.) lateral to the anus downward to a midpoint in the perineum. After this, a similar incision is made on the opposite side. The coccyx is then disarticulated and removed, and the fascia propria is incised in the coccygeal region. Now the perirectal fat, fascia and levator ani muscles are widely removed from both sides of the bowel. The rectum is next freed by cautery dissection from the prostate gland or posterior vaginal wall. In the male, caution must be taken during excision to avoid injury of the membranous portion of the urethra. After this, the upper part of the rectum is freed from the hollow of the sacrum by the surgeon's passing his left hand cephalad between the bowel and the sacrum until the inverted end of the sigmoid is reached. It is then grasped and drawn downward into the perineal wound; the lateral ligaments or rectal stalks are divided and the entire distal segment is removed. Five grams (75 grains) of microcrystalline sulfathiazole is placed in the peritoneal cavity. The perineum is closed transversely, and the perineal wound is packed by means of, first, a large square of synthetic silk, and second, a 4-inch (10 cm.) gauze pack varying in length from 4 to 6 feet (122 to 183 cm.). The cutaneous edges are approximated about the pack with catgut sutures. The pack is removed on the third postoperative day. On the fifth or sixth postoperative day, daily sitz baths are begun.

I have performed this particular operation about seventy-five times, without a death. After the operation the patient ought to remain in bed in the hospital for ten to fourteen days. In my experience, complete healing has ensued in six to twelve days.

It will be noticed that in the first stage of this technique the superior hemorrhoidal vessels are sectioned. This in no case has caused necrosis of the distal segment of bowel, but some degree of microscopic necrosis of the carcinous lesion does result.

When the operation is carried out thus, I believe it is radical, and I think it is valuable.

The so-called Kraske operation for carcinoma of the rectum is both safe and sufficiently radical, in my opinion. The procedure consists of performance of an abdominal loop or double-barrel type of colostomy, followed in ten days or two weeks by perineal or posterior resection of the rectum and rectosigmoid. The details of the technique are well known; I shall merely present those points which in my experience have produced the most satisfactory results.

In the Kraske procedure the abdominal cavity is entered and explored by means of a low left rectus incision. A loop of distal descending colon or sigmoid is brought out and fixed in the midportion of the incision. Fixation is accomplished by the passing of a rubber-covered glass tube through the mesentery of the bowel. The abdominal wall then is closed about the small loop or knuckle of the exteriorized portion of colon. Great caution should be exercised in the performance of this type of colostomy so that it can be certain that the abdominal wall will not be closed too tightly around the bowel. If this error is made, marked edema of the exteriorized portion of the bowel will ensue, causing a poorly functioning colonic stoma. Also, any slack or redundancy of that segment of the bowel proximal to the site of the colostomy often will permit the proximal segment of the bowel to prolapse, which means that amputation will be required. With a single exception, the second and final stage of the operation is carried out as is the two-stage combined abdominoperineal operation which I have already described. The exception is that in the Kraske type of operation with performance of loop colostomy, the peritoneum is opened during resection of the rectum, and the remaining distal end of the sigmoid flexure is inverted and replaced in the peritoneal cavity. The posterior incision is packed as previously described herein.

Carcinoma of the Lower Part of the Sigmoid or Rectosigmoid

The Hartmann Operation.—For a long time I had been impressed by the promising results obtained by the Hartmann operation for carcinoma of the rectosigmoid. Briefly, the details of this technique are as follows:

The operation is characterized by a one-stage resection in which the rectosigmoid or upper part of the rectum is cut across distal to the neoplasm. The upper part

of the rectum is then inverted, and the remaining pelvic portion of the colon, together with the neoplasm, is mobilized. Then the bowel is divided in the region of the distal portion of the descending colon. After the intervening segment of bowel has been removed, the proximal end of the descending colon is brought out as is done in the performance of single-barrel colostomy.

When I investigated some of the results of this operation, I noticed that many of the patients for whom it had been done were alive and in good health years later, without evidence of recurrence of the malignant process in that part of the rectum which remained. After I had reviewed a considerable number of specimens of lesions removed during this type of operation, I was further impressed by the fact that the site of amputation in the rectosigmoid or rectum invariably had been in close proximity to the carcinous process.

The relationship between the site of amputation and the apparently superior survival rates among the patients was provocative. Was it valid to conclude that carcinoma in this particular region or segment of bowel rarely, if ever, metastasizes downward? Diligent search of the pertinent literature indicated that carcinoma only very rarely metastasized downward into the lymph nodes for more than 2 cm., and that when such spread did occur, the proximal lymphatic structures were blocked by the carcinous process.

Low Anterior Resection and Preservation of Intestinal Continuity.—With this information as a reasonable basis, I interested myself in the development of a procedure which would permit re-establishment of the continuity of the bowel after excision of the carcinous lesions of the lower part of the sigmoid. I began to employ so-called low anterior resection, followed by re-establishment of the continuity of the bowel. My opinion is that lesions which occur 6 to 20 cm. from the anal margin can be treated suitably by this procedure. The technical details follow:

The abdominal cavity is opened by means of a long, low, left rectus type of incision. An exploratory procedure is carried out. The patient is in the deep Trendelenburg position. First, the liver is palpated to detect or rule out distant metastasis. Next the colon, beginning with the cecum, is examined to discover or rule out the possible coexistence of other malignant lesions. The low sigmoidal lesion is palpated. If resection is thought to be feasible, the procedure is begun by incision of the fused lateral peritoneum from near the splenic flexure of the colon down to the pelvic peritoneal fold. The left ureter is identified and isolated. Next, the posterior parietal peritoneum is opened mesially at a point immediately cephalad to the superior hemorrhoidal vessels. The mesial peritoneal incision is extended downward and along the base of the mesosigmoid and is curved around the rectovesical or rectocervical neck. The entire pelvic colon, rectosigmoid and upper part of the rectum are then mobilized by freeing the mesosigmoid from the sacrum, beginning at the sacral promontory and extending to the tip of the coccyx, by means of sharp and blunt dissection. The rectal ampulla is next mobilized from the vagina or seminal vesicles and prostate gland. In carcinoma of the rectosigmoid situated at the pelvic peritoneal fold, it is necessary, in order to obtain satisfactory mobilization, to divide and ligate the lateral rectal stalks or ligaments, which contain the middle hemorrhoidal vessels. When complete mobilization of the entire pelvic portions of the colon and upper part of the rectum has been obtained, the superior hemorrhoidal vessels are divided and ligated, as are the vessels in the mesentery of the distal portion of the descending colon. The latter is then divided between Payr clamps.

Long, especially constructed curved rubber-covered clamps are then placed across the bowel, usually across the upper portion of the rectum, or as far distal as possible from the lower margin of the neoplasm. The bowel is now divided between the clamps, and that part of the pelvic colon containing the tumor is removed. The descending colon, already sufficiently mobilized, is brought down and anastomosed as an open end-to-end procedure. Chromic catgut is employed. Five grams (75 grains) of sulfathiazole are sprinkled into the hollow of the sacrum. A long Penrose cigaret drain is employed, one end being inserted into the sacral hollow near the tip of the coccyx and the other end being brought out through the lower end of the abdominal incision. This drain is lifted out—not pulled out—on the eighth or ninth postoperative day. The lateral and mesial layers of the posterior parietal peritoneum are sutured to the edges of the bowel, thus obviating any defect in the pelvis. The suture line of the anastomosis is kept intraperitoneal, if possible; however in low sigmoidal lesions this sometimes is impossible. Thus, resection and re-establishment of continuity of the bowel have been carried out.

Since such a type of anastomosis is difficult, it is my practice to establish a temporary loop type of transverse colonic stoma. This is accomplished by the bringing of a small segment of the transverse colon to the exterior in the upper end of the primary incision. This segment of the bowel is held in place by means of a rubber-covered glass tube passed beneath the gut through its mesentery. The abdomen is then closed about the loop of exteriorized colon. The latter is opened by means of cautery on the day after resection. Such a colonic stoma may be closed within three or four weeks after resection. Spur-crushing clamps are employed prior to closure of the stoma in about 75 per cent of the cases. An intraperitoneal type of closure always is employed.

From 1930 through 1945 I performed low anterior resection for about 500 patients. At abdom-

inal surgical exploration, 340 of these 500 patients had no evidence of distant metastasis, despite the fact that in many instances involvement of those lymph nodes adjacent to the primary lesion had been detected.

Hence, it seems apparent that in these 340 cases low anterior resection was carried out in the hope that permanent relief would be obtained thereby. The distance of the primary malignant lesion from the anal margin, as disclosed at proctoscopic examination, ranged from 6 to 20 cm. In ninety cases the distance of the malignant lesion from the dentate margin ranged from 6 to 10 cm. In the remaining 250 cases the distance of the carcinoma in the rectosigmoid and sigmoid from the anal margin ranged from 11 to 20 cm.

In the earlier operations the mortality rate per 100 patients varied from 9 to 13 per cent. In this respect I may point out that since the sulfonamide compounds were introduced, the hospital mortality rate associated with the procedure has decreased impressively. For instance, from 1941 to 1945 I carried out conservative low anterior resection for 184 patients, with only two deaths. In one case death was caused by infection with Type III pneumococci; in the other case death was attributed to coronary disease.

The five-year survival rate in 272 cases in which I have performed the two-stage low anterior type of resection, with re-establishment of the continuity of the bowel, for carcinoma of the lower part of the sigmoid flexure, is 67.7 per cent. This rate, I am convinced, compares favorably with the rate associated with any type of surgical procedure for the condition in question, including those operations which necessitate establishment of a permanent colonic stoma.

Chemotherapy and Preoperative and Postoperative Care

Chemotherapy.—A number of surgeons have voiced doubts as to the value of the sulfonamide compounds in procedures such as those concerned herein. I think, however, that the work of Poth and his associates, which has been substantiated clinically by Benson and me, demonstrates conclusively that the preoperative use of sulfasuxidine or sulfathaladine, plus the use of sulfathiazole at the completion of each operation, greatly diminishes the incidence of infection. This, in turn, means that the morbidity and mortality rates have been lowered thereby.

According to the plan which I employ at present, the administration of sulfasuxidine is begun five to seven days before the date of operation. During this period a total of 1,000 to 1,200 grains (65 to 78 gm.) is given orally in divided doses, at intervals of four hours.

At the completion of resection and closure of the colonic stoma, 75 grains (5 gm.) of sulfathiazole is placed in the abdominal cavity near the site of anastomosis.

Preoperative and Postoperative Care.—A nonresidue diet, high in carbohydrate value, is prescribed. Gentle catharsis is assured by the administration of sodium phosphate during the first two days before the operation; in this period 2 to 4 drams (about 8 to 16 gm.) are given each four hours. Likewise, beginning two days before the surgical treatment, the patient's rectum is gently irrigated twice daily with saline solution.

On the third day postoperatively 2 fluid drams (7 c.c.) of paregoric is administered each three hours.

Summary and Conclusions

The surgical treatment of carcinoma of the sigmoid flexure and rectum often is more difficult than that of carcinoma situated anywhere else in the large intestine. It is not always possible to reestablish continuity of the bowel after excision of a carcinous lesion in the sigmoid and rectum, for local excision of such a neoplasm is possible only in a very few cases. The merits and disadvantages of Hochenegg's so-called pull-through operation for carcinoma of the rectum are considered, as are the Miles and Kraske or Lockhart-Mummery procedures. A modification of the Miles operation is presented, and mention is made of the value of chemotherapy and of certain details of preoperative and postoperative care.

MSMS

CONSUMERS IN NO RUSH FOR CREDIT

The Nation's consumers have showed no rush to get deeper into debt since all federal controls over credit were dropped.

A national survey of department store and credit groups by the Associated Press disclosed little if any freer use of credit and only limited expansion of sales volume because of more liberal credit.

A handful of exceptions threw the general picture into sharper relief.

This behavior contradicted widely circulated predictions of a rush to buy "on the cuff" when elimination of controls paved the way for freer terms.

Hemochromatosis

Review of Literature and Presentation of a Case

By Henry L. Smith, M.D., F.A.C.P.,
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Henry L. Smith, M.D.

TROISIER, in 1871, first described a "bronze cachexia" occurring in diabetes. Ten years later, Hanot and Chaufford called attention to a condition which they termed "bronze diabetes." It is undoubtedly true that these diseases were the same as that described and named "hemochromatosis" by von Rechlinghausen in 1899. It consisted essentially of a rare disorder of iron metabolism, characterized by a clinical triad of hepatic enlargement, diabetes and pigmentation of the skin.

The following case report, that of a forty-four-year-old man, is presented because of its typical clinical features and for a re-appraisal of the literature on the subject.

Case Report

A forty-four-year-old white man was admitted to the Mount Carmel Mercy Hospital on April 30, 1946, with chief complaints of constipation and a 20-lb. weight loss in six weeks. He had noted flatulunce and some epigastric pain after meals. Two weeks previously he had an attack of weakness, dizziness and palpitation. His past history was essentially negative except for severe burns which were suffered in a building explosion in 1936. Soon after that, he noted a brownish pigmentation appearing over his arms, abdomen and legs.

On physical examination, it was noted that his skin was dry and had a peculiar dirty brown scaly pigmentation, particularly on the neck, arms, umbilicus, groins, legs and ankles. His sclerae were slightly yellow. A large hard mass was palpated in the epigastric region, extending about four finger-breadths below the right costal margin. The extremities showed evidence of old burn scars.

The admission blood count showed red blood cells, 3,750,000; hemoglobin, 11.6 gm. per 100 c.c.; white blood cells, 6,400, with 46 per cent neutrophiles, 7 per cent stab cells, 4 per cent eosinophiles, 1 per cent basophiles and 42 per cent lymphocytes. Subsequent blood counts varied slightly from the above. The admission urine showed a 4-plus sugar with no acetone. The following week the urines varied from a 4-plus sugar with 3-plus acetone to a trace of sugar and no acetone in the terminal three days. The fasting blood sugar ranged from 173 to 200 mg. per 100 c.c. The icterus index was 10. The blood chloride was 450 mg. per 100 c.c. The Kahn test was negative. The cephaline cholesterol flocculation test was 2 plus. Taken terminally, the nonprotein nitrogen was 53 mg. per 100 c.c. of blood.

He was put on a regime of fluids and insulin according to fractional urine analysis and fasting blood sugars. Terminally, he was given glucose intravenously. His course was increasingly downhill. He developed ascites, anuria, coma and finally expired after a sixteen-day hospital stay. The clinical diagnosis varied from Addison's disease or a malignancy of biliary tract to hemochromatosis. The latter was confirmed by a Fishback skin test, which gave a positive reaction, and also by a skin biopsy which was positive for hemosiderin.

Autopsy.—The body was that of a well-developed and only fairly well-nourished forty-four-year-old white man weighing approximately 170 pounds. The skin had a peculiar bronze-like sheen throughout, which was more pronounced on the neck, axillae, hands, umbilicus, groins, legs and ankles. Several white scarred areas covered the left shoulder, wrist, right elbow, back, right tibia and left ankle.

The peritoneal cavity contained 1,000 c.c. of clear yellow fluid. The liver lay four finger-breadths below the xiphoid process. The spleen extended 2 cm. below the left costal margin. The thyroid weighed 20 gm. and had a peculiar rusty brown tinge. The heart weighed 510 gm. The myocardium was orange-brown in color. The left ventricle was dilated and hypertrophied. Moderate enlargement was present of all cardiac chambers. The right lung weighed 400 gm. The left lung weighed 390 gm. and its lower lobe was passively congested. The spleen weighed 450 gm. Its cut surface was firm and red to mahogany brown in color, with distinct Malpighian bodies. The lymph nodes, particularly the mesenteric, periaortic, and iliac, were firm and dark brown in color. The liver weighed 2,600 gm., and its external surface was studded with firm, hob-nailed nodules having a rusty brown appearance. On application of potassium ferrocyanide and HCl, the brown turned blue. The cut surface revealed a firm brown parenchyma circumscribed by a varying amount of connective tissue. The portal radicles were dilated. The gall bladder was essentially normal. The pancreas weighed 150 gm. and presented a dark brown surface. The esophagus was grossly normal. There were no varices. The stomach mucosa contained some brownish pigmented areas. The adrenals were necrotic and revealed a thinned-out brownish cortex. Each kidney weighed 200 gm. and was brown in color. The bladder, ureters and sex organs were normal. The head and spinal cord were not examined.

Microscopic Findings.—Sections of skin revealed atrophic keratotic squamous epithelium in which the rete pegs were very small. The basal cell layer contained an

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increased amount of brown pigment. The underlying dermis was the site of a low-grade chronic inflammatory process consisting of a few lymphocytes and plasma cells and perivascular infiltration. In addition, a few large mononuclear cells containing brown pigment in the cytoplasm were noted. Similar brown pigment was noted in and around small sweat glands. Some of the pigment was deposited in the sweat gland epithelium. Large intra- and inter-cellular brown pigment deposits were present in the thyroid sections. The greater portion of the pigment was deposited in the vesicular epithelium resulting in some degeneration and atrophy of these elements. The lungs showed pulmonary edema and congestion. Sections of cardiac muscle revealed extensive brown pigment deposits throughout the myocardium. The deposits were most prominent near the nuclei. These deposits resulted in a marked parenchymatous degeneration with irregular hypertrophy of the remaining viable fibres. The coronary arteries as well as the aorta revealed moderate atheromatosis with brown pigmentation in the adventitia.

The parenchyma of the liver was divided into islets of variable size and shape by strands of fibrous connective tissue. The parenchymal cells contained variable quantities of brown pigment. As a result, some cells were atrophic and the capillaries were dilated. In some cells, the pigment was seen as granules in the cytoplasm near the nucleus. In other cells, the nucleus was hidden by a solid mass of brown pigment. the Kupffer cells contained similar pigment deposits. The connective tissue separating the islets was fibroblastic in character and undergoing hyaline degeneration. Numerous bile capillaries were scattered throughout the tissue. The lymph node architecture was obscured by large brown pigment deposits which were seen both intra- and extra-cellularly. The spleen showed areas of passive congestion and moderate hemosiderosis. The acinar cells of the pancreas were loaded with a brown pigment, resulting in partial and total atrophy of the cellular elements in many areas. Only a few islands of Langerhans contained this brown pigment. Areas of fibrosis and atrophy were conspicuous. The stomach contained brown pigment in the gastric glands. The lining cells of the large and small intestines had brown pigment. Large brown pigment deposits were noted in the cortical portion of the adrenals. Pigmentation was also noted in the epithelium of all the tubular elements of the kidneys. The bladder and prostate contained the brown pigment deposits. All sections were stained by Turnbull's Blue Method for hemosiderin, and characteristic bright blue pigment deposits were noted in the organs indicated above.

Chemical Examination of Liver.—One hundred grams of wet liver contained 1.92 gm. of iron (normal, .1 cent). Therefore, the entire liver (2,600 gm.) contained a total of 49.92 gm. Five hundred grams of wet liver contained 18.0 mg. of copper (normal, 2.98 mg.). Thus, chemically there were enormous amounts of recoverable iron and copper from the liver alone.

Final Diagnosis.—Hemochromatosis with generalized hemosiderosis involving the liver, pancreas, thyroid, spleen, lymph glands, adrenals and kidneys; portal cirrhosis of the liver; chronic passive congestion of lungs; left ventricular dilatation and hypertrophy.

Diagnosis

Age.—The average age for a full-blown hemochromatosis to appear, as given by Sheldon[20,21] in his monumental work, was forty-five to fifty years old. His youngest patient was twenty years old. Butt and Wilder's[6] series of thirty cases at the Mayo Clinic listed fifty-two years as the average age. Chesner[9] has reported a fourteen-year-old white boy who was proven to have hemochromatosis at autopsy. Our case readily fell into the average age group.

Sex.—Ever since Sheldon published his series, it has been stated that men are predominantly involved. Twenty-nine of Wilder's cases were males. In Gillman and Gillman's[13] excellent review of the structure of liver in pellagra and pigmentary cirrhosis, women were affected in a much higher incidence than previously reported. However, the disease appeared to be more progressive and advanced in males, giving signs of atrophic cirrhosis, distended abdominal veins and ascites.

Heredity.—Lawrence[15] described a family of nine in which two brothers had proven hemochromatosis. As a result, he has suggested the possibility that hemochromatosis may be a sex-linked hereditary disease transmitted by women and affecting primarily men. Sheldon reported at least five instances in which brothers were affected by the same disease. This led him to believe that hemochromatosis was an inborn error of metabolism. This is completely denied by Gillman and Gillman. Further elaboration on this is given under "Pathogenesis."

Symptoms and Signs.—The pigmentation of the skin is described as being of a shade between the typical melanosis of Addison's disease and the grey slate-like color of argyria. Its distribution usually is general, although the exposed areas of the skin are affected most and they alone may reveal the characteristic color. In Sheldon's series, pigmentation of the skin constituted the first symptom of disease in 25.7 per cent of the cases and was found in 83.8 per cent of his series. In the Mayo series,[6] it was the first symptom noted in 40 per cent of the cases. Cantarow[8] states that up to 22 per cent of his patients showed no cutaneous pig-

mentation. Lisa and Hart[16] contend that 75 per cent of the cases will have no bronzing. The pigmentation may appear early or late. Wilder's series showed pigmentation to be present for as long as sixteen years or as short as six months before death. In our case the pigmentation had been present for ten years.

Diabetes was present in 25.7 per cent as the initial symptom and was finally present in 70 per cent of Sheldon's cases. Butt and Wilder reported an 86 per cent incidence of diabetes per laboratory means.

Hepatomegaly was present in 92 per cent of Sheldon's series and in 90 per cent of Butt and Wilder's series. In the latter instance, it was greatly enlarged in three of the cases. They noted splenomegaly in 30 per cent of their cases. Sheldon noticed this in 60 per cent of his cases.

Asthenia appears to be a frequent complaint. This, coupled with weight loss, has struck us as being prevalent in the cases reported throughout literature. This was particularly noted in the cases which were reported by Butt and Wilder, Cantarow, Darnell,[11] Beardwood and Rouse.[1] Our case was no exception. All of Gillman and Gillman's patients had severe malnutrition, and this plays an important part in their theory of the pathogenesis of hemochromatosis.

Gastric upsets frequently are the presenting symptom which send the patient to the hospital, as in our case.

Sexual hypoplasia was stressed in Sheldon's original work. This also consists of alteration of secondary sexual charactertistics: loss of hair in the axillas and on the chest and trunk, feminine distribution of pubic hair, and impotence. Darnell[11] noted a loss of hair in three of his cases, impotence in two, and atrophy of testes in one. Other series reviewed did not stress hypoplasia. It was not present in our patient.

Anemia did not appear to be of major significance in Sheldon's series. Yet Zeltmacher and Bevans[24] believe that there is more than a mere coincidence between aplastic anemia and hemochromatosis. In Chesner's case the anemia preceded the onset of all other symptoms by approximately six years. Bomford and Rhoads[4] reported three cases of aplastic anemia. Our case was not considered anemic.

Chemical Test for Hemochromatosis.— Fishback[12] has devised a method for the demonstration of iron in the skin which is of aid in the diagnosis of hemochromatosis. The technique consists simply of mixing equal parts of sterile solutions of 0.5 per cent potassium ferrocyanide and 0.01 normal HCl and injecting the solution intradermally so as to form a wheal. A positive test is present if a slight blue color becomes evident almost immediately which darkens to a deep blue within an hour. A narrow red zone appears at the periphery of the wheal and persists throughout the slow concentration of the blue test spot until it has completely faded in about two weeks. A negative test is evidenced by a white wheal with the peripheral red zone, the latter still taking about two weeks to completely fade. No harmful or injurious effects have been noted, and the test appears specific for this disease. In our patient, the skin test was positive, and we would consider it fairly reliable for suspected hemochromatosis.

If the disease is fully developed, the diagnosis of hemochromatosis is easy. In early stages it offers difficulties. When only one factor of the triad of pigmentation, diabetes mellitus and hepatic cirrhosis is present, the danger of incorrect diagnosis is greatly increased, and the disease may escape consideration unless a high degree of suspicion is entertained. Hence, a biopsy of the skin may be of some aid. Montgomery and O'Leary, as quoted by Butt and Wilder,[7] regard the finding of iron or hemosiderin in the propria of the sweat glands and about the capillaries of the upper part of the cutis to be diagnostic.

In another recent case seen at our hospital, and in which there was no skin pigmentation, diagnosis was definitely made from a liver biopsy taken through the peritoneoscope. This was the case of a seventy-five-year-old man with diabetes, hepatomegalia, ascites and no pigmentation of the skin. The Fishback skin test for hemosiderin was negative. Thus, in cases without pigmentation where hemochromatosis is suspected, the use of peritoneoscopy and liver biopsy offers a valuable diagnostic procedure. Bockus[3] mentions the use of this procedure in puzzling cases where the diagnosis cannot otherwise be established.

Pathological Physiology

The disease is characterized by the deposition of pigments, fibrotic changes and cellular degeneration in certain parenchymatous organs, with associated physiological changes producing the symptoms.

Thus the hemosiderin which loads the hepatic cells, and to a lesser degree the Kupffer cells, leads to the slow destruction of the liver cells, followed by proliferation of the unaffected cells and increase of the connective tissue. The same thing happens in the pancreas, and in this way there develops marked cirrhosis of both organs, which assume a chestnut-brown color as a result of the deposition of pigments. Due to excessive destruction of the hepatic parenchyma, the liver is unable to store glucose, and therefore it is retained in the blood and spilled into the urine. Degenerative changes in the isles of Langerhans may be an added factor in this process. Beardwood and Rouse regard this destruction as being progressive so that the diabetes produced is practically uncontrollable.

The parathyroids are also loaded with hemosiderin. According to Boyd,[5] disturbance of calcium metabolism may occur and the tissue contain an excess of calcium. There may be an osteoporosis. We have not encountered the latter in reviewing the literature.

The anterior lobe of the pituitary gland may be depressed by deposits of hemosiderin in a manner comparable to that in which the activity of the isles of Langerhans are depressed. Thus another factor is to be considered in diabetes. The problem of asthenia and sexual hypoplasia may also be attributable in part to the depressed function of the pituitary gland.

The adrenals which are inactivated by deposits of hemosiderin may be contributory factors to production of asthenia.

Striated muscle is affected to a very great extent. The heart muscle is pigmented in about 90 per cent of the cases according to Sheldon. Hence, cardiac hypertrophy and dilatation with resultant failure may be postulated as the cause of death in some of the patients with hemochromatosis.

Smooth muscle practically never contains hemosiderin. Deposits may be seen in the smooth muscle of the genital tract, small intestine and blood vessels, however.

Our case essentially presented all the above features. The factors leading to death in our case were numerous. First, as a result of fibrotic changes in the liver, portal obstruction occurred, producing ascites and dependent edema. Cause of death may have been liver insufficiency. Secondly, there may have been an element of myocardial failure due to the large hemosiderin deposits in the myocardium giving rise to ascites, edema and respiratory and cardiac distress. Thirdly, diabetic coma may have played a role.

The life expectancy varies with the severity of the lesions. In Butt and Wilder's series, some lived thirteen years and others only eight months from the time the diagnosis was made.

Pathogenesis

Sheldon in his exhaustive work on hemochromatosis states that an explanation of the disease must at least be capable of embracing the following features: (a) the deposits of hemosiderin and hemofuscin, (b) the age incidence, (c) sex incidence, (d) the cirrhosis of the liver and other organs, and (e) the increase of copper. He concluded that the most reasonable explanation was that the disease is due to an inborn error of metabolism with accumulations of small amounts of pigment over a long period of time. He did not know the exact nature of this metabolic error but believed it concerns the inner metabolism of probably all the cells in the body. It manifests itself in two ways: by the production of melanin in certain situations, as in skin and smooth muscle, and by the formation of an iron-containing compound in nearly all the tissues. He theorized that in the course of time the products of this error of metabolism gradually accumulate as the characteristic pigments, and ultimately lead to the final stage of the disease with its characteristic clinical symptoms. The process is so slow that the symptoms do not usually appear till middle life. The majority of writers on this subject concur with this opinion.

Mallory, Parker and Nye[17] produced the disease in animals by feeding copper, and their experiments were confirmed by Hall and Butt.[14] The latter produced pigment cirrhosis in rabbits, in sheep, and to a lesser extent in white rats, by feeding these animals copper acetate. This work has largely been discarded as later workers could not confirm Mallory's work.

Another interesting theory has been suggested by a group of authors who described hemochromatosis in association with aplastic anemia. They believe that, in those patients observed after they have been kept alive by a large number of blood transfusions, increased hemolysis may be the etiological factor of hemochromatosis. They suggest that the iron derived from the destruction of intrinsic and transfused blood is deposited in a cir-

rhotic liver. However, others experienced in the consequences of blood transfusions have not generally accepted such etiologic relationship.[22] Also, experimental attempts to reproduce hemochromatosis by repeated transfusions, by hemolytic agents, and by injections of hemoglobin or dialized iron have not been successful.[18,19] In Chesner's case, the patient received a total of 6 liters of blood over a nine-month period, or 2.75 gm. of iron. The amount recovered from the liver alone was 47 gm. From these calculations it is clear that the pigmentation cannot be explained by retention of transfused iron.

Gillman and Gillman, from South Africa, have written a most interesting paper on the structure of the liver in pellagra. If this work is confirmed, it would constitute a new approach to the study of hemochromatosis. On the basis of 400 liver biopsies in 120 patients with pellagra, they conclude that hemochromatosis is one of the commoner sequalae of pellagra. They saw no evidence of increased destruction of blood. They noted that the earliest evidence of the appearance of iron is preceded by visible changes in the mitochondria lying immediately distal to the nucleus. They concluded that hemofuscin and hemosiderin are derived from these pre-existing elements, mitochondria, within the liver cells. Hence, they are not derived from the blood. They thus feel that hemofuscin should be known as cytolipochrome and hemosiderin as cytosiderin. Claude[10] claimed to have demonstrated that the mitochondria contain cytochrome-oxidase, copper, ribonuclein, succinine dehydrogenase and phospholipids. If this work and Gillman's are confirmed, a new important link would be established between biochemistry and morphology. Soon it may be possible to employ morphologic indicators in tracking down some of the obscure biochemical phenomena which are known to occur in normal and diseased cells.

Gillman and Gillman claim that their theory would fit into Sheldon's criteria very satisfactorily. The deposits of hemosiderin and hemofuscin and the increase of copper, which Sheldon claimed must be accounted for, are the result of disruption of the mitochondria, according to Gillman and Gillman. The constituents of the mitochondria, namely, cytolipochrome, cytosiderin and copper, appear as disruption occurs. As to etiology, they claim it is a manisfestation of chronic malnutrition. They disagree entirely with Sheldon that this disease is the result of an inborn error of metabolism. They found through their liver biopsies that pigmentary cirrhosis is concomitant at least with some forms of malnutrition in South Africa and that the degree of pigmentation is a good indicator of the chronicity of the malnutrition. They further concluded that hemochromatosis is not an uncommon disease in Africa. This was based upon observations of 700 livers from autopsies in sudden and violent deaths of the natives.

Bean, Spies and Blankenhorn,[2] in quoting Gore, reported a case of frank pellagra associated with hemochromatosis. No attempt was made to any correlation between the two. In reviewing the literature, we were particularly interested in the nutritional states of the cases reported. Weight loss was commonly cited, but further comment or elaboration was not made. Our patient, terminally, appeared to be somewhat malnourished. Thus, through inadequate information, we are unable to discuss these cases from the nutritional point of view in line with Gillman and Gillman's recent concept.

Treatment

Wilder and others have emphasized that the most important factor in prolonging life has been the adequate control of diabetes. The first diabetic picture is usually quite mild but gradually increases in severity until at times it is quite refractory to treatment. As the disease progresses, the insulin requirement increases. Wohl and Davis[23] reported a case in which the discoloration of the skin cleared to a considerable degree after the diabetes was controlled with diet and insulin. However, this is an isolated instance. The usual course is downhill in the majority of cases.

Darnell advocated diets relatively rich in carbohydrate in order to combat hepatic insufficiency. Otherwise, the treatment is palliative.

From the trend of the recent work reviewed, a new approach as to the prevention and therapy of the puzzling disease, hemochromatosis, may be in the offing.

Summary and Conclusion

1. A typical case of hemochromatosis is presented.

2. The diagnosis is based upon clinical features, pigmentation, diabetes, and hepatomegaly, and upon the findings of pigment cirrhosis of the liver and pancreas, and siderosis in other organs.

3. A correlation is made between signs and symptoms and the pathological physiology of the disease.

4. In recent literature the association of hemochromatosis with cases of anemia has been noted. The possible relationship between blood transfusions given to these cases has been suggested as the cause of hemochromatosis. We do not believe that this question has been definitely answered.

5. It has been suggested that hemochromatosis is one of the manifestations of chronic malnutrition and that it is a common disease in Africans. The hemosiderin and hemofuscin pigments are thought to have a common origin from mitochondria, and since they arise within the liver cells, the names of "cytosiderin" and "cytolipochrome" have been suggested to replace the old and misleading terms.

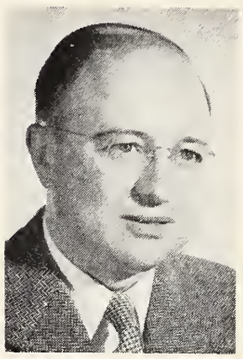
6. Due to inadequate information in a review of the cases throughout the literature, we cannot substantiate the aforementioned theory. We believe that it is a most interesting concept and if confirmed would constitute a new approach to the study of hemochromatosis. Gillman and Gillman have made a definite contribution to the pathogenesis of hemochromatosis.

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Rocky Mountain Spotted Fever Appears in Michigan

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THE PROVINCIALISM which is attached to the name Rocky Mountain spotted fever is misleading, in that all but seven states* have reported the incidence of this disease. Two cases of spotted fever in Michigan occurred several years ago,† but it was conclusively proved that these patients were infected in Wyoming.[20] In 1945 a positive diagnosis was made in a patient who had never left the state. The recent death of this patient prompts a more detailed report of what probably will be considered the first endemic case of Rocky Mountain spotted fever in Michigan.[22]

The earliest accounts of Rocky Mountain spotted fever came from Idaho and Montana; and the disease has, no doubt, existed in these states since the first settlement by white men. By 1920 the disease was distributed throughout the Rocky Mountain area and the Dakotas, and in 1931 it was identified in the east.[4] Rapid recognition of its prevalence followed in the central states. As a result of this spread, spotted fever threatens to assume proportions of national significance, and it is imperative that the physicians in Michigan be alerted to have at least a working knowledge of its manifestations.

Historical accounts replete with details of the clinical, epidemiological and pathological manifestations of spotted fever are unequaled in the early writing of Wolbach,[36,37] Ricketts,[23] Spencer[29] and Parker.[21] The current articles by Wolbach,[38] Parker,[30] Topping,[25,32,34] Dyer,[7] Yeomans,[28,40] Rose,[24] Harrell[17] and Baker[5] give an accurate description of clinical and therapeutic advances in spotted fever as it exists today.

Rocky Mountain spotted fever is a rickettsial

*Connecticut, Maine, New Hampshire, Rhode Island, Vermont, Wisconsin and Mississippi.

†These two cases were reported in September, 1941, and both patients died. They were attended by Doctor Charley J. Smyth, Medical Director of the William J. Seymour Hospital, Eloise, Michigan.

disease (Dermacentroxenus rickettsi), and the rickettsiae are parasites of ticks which serve as mechanical vectors in the spread of spotted fever. The wood tick (Dermacentor andersoni), the American dog tick (D. variabilis), the lone star tick (Amblyomma americanum) in the south, and other tick vectors have been observed. Spotted fever is primarily a disease of animals, and human infections are accidental, since man plays no direct role either in perpetuating the disease or in the life cycle of the parasite vectors.[19]

Transmission

The transmission of the disease in this particular case remains a moot question. Epidemiological studies were not carried out by the state or national laboratories. It is possible that a reservoir of the disease exists in local domestic animals or in rodents. Such an assumption, however, is difficult to prove since the larger animals do not have actual symptoms during the infectious phase of the disease. In nature, rodents dead or ill with the disease have never been encountered.

Veterinarians‡ in this county report that dogs are heavily infested with ticks (Dermacentor variabilis) but recognition of spotted fever is very unlikely, in that the older dogs have inapparent infections and the younger dogs react with fever and respiratory symptoms which would probably go unnoticed and undiagnosed.

A possible approach to the epidemiological problem is suggested by Topping,[25] who studied the incidence of the infection in dogs by using the complement fixation method. Topping showed that in infected regions there was a high incidence of infections among dogs. Of interest in his study is the fact that dogs from the Chicago pound did not give a positive reaction.

Ellison[9] has made the highly significant observation that each of the species of Dermacentor known to parasitize small mamals has a distribution coincidental with a species of rabbit. The cottontail rabbit (Sylvilagus nattallia) is an important host to the immature stages of the wood tick (D. andersoni) and one of the few mammals that is host to all stages of this tick. Thus, while suspicion is cast by these observations, positive statements regarding a reservoir in rabbits cannot be made.

Aside from propagation of the disease in ticks through susceptible animals (acquired transmission), rickettsiae are also transmitted through mating of ticks, and by the female to her egg and then to her progeny (hereditary transmission). These facts further complicate epidemiological investigations.

The developmental cycle of the tick-egg, larva, nymph, and adult—extends over a two-year period. It now has been two years since the case in question occurred, and further infections have not been reported. Only time will tell if spotted fever has become endemic in Michigan but the possibility, nevertheless, remains.

From 450 to 600 cases of spotted fever are reported each year in the United States, and while the virulence varies greatly in different localities, the fatality rate for the entire nation is approximately 23 per cent. Actual figures on the morbidity of the disease are not available, but extended convalescences with or without sequellae are not uncommon. The clinical picture in spotted fever is not too difficult to recognize, and the facilities of our state laboratory make is possible to confirm clinical impressions. The present case is illustrative of the usual clinical course and morbid sequellae.

Case Report

A male patient, aged forty-seven, previously in excellent health, was first seen August 17, 1945. On the night of August 7 he noticed chilliness, slight dizziness and nausea. Later that night he vomited several times. During the next day he developed a slight cough and was seen by a physician who gave him "sulfa tablets." The patient was admitted to the St. Joseph Sanitarium on August 14 by the family physician. On admission he complained of feeling feverish and of aching throughout the entire body. He had intense vertigo, severe headache, insomnia, generalized weakness, anorexia, nonproductive cough and deafness on the left side. The symptoms enumerated became progressively worse, and during the next three days he had epistaxis, dysphagia and bladder and bowel incontinence.

On physical examination the patient was stuporous and not co-operative. His rectal temperature was 104°. The respiratory rate varied from 26 to 35 per minute. There was occasional pulse hurry but the rate seldom exceeded 100 per minute. His throat was moderately hyperemic; breath sounds were diminished throughout the chest posteriorly, and a few râles were heard at the bases. His eardrums were markedly retracted but normal landmarks were visualized. There was obvious deafness on the left. The palpebral and bulbar conjunctiva were markedly hyperemic. His pupils were contracted and fixed. The cremasteric reflexes were absent. The spleen was not palpable. Lymph glands were not palpable and the skin was normal. The remainder of the physical examination yielded no significant data.

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Concurrent urinalyses showed albumin grade II and a few coarse granular casts. The hemoglobin and red blood count were normal; and the white count varied from 11,800 to 18,200, with 92 per cent polymorphonuclear cells and 8 per cent lymphocytes. A blood culture for pyogenic organisms was negative and remained negative for eighteen consecutive days. Agglutinations for typhoid, paratyphoid and brucellosis were negative. There were no cells in the spinal fluid, and the culture of the spinal fluid yielded no growth for pyogenic organisms. The Mazzine test was negative, Routine x-ray studies showed the paranasal sinuses to be clear, and a clinical investigation of the sinuses was negative** A six-foot x-ray of the chest showed a slight increase in the density of the bronchial vascular trunks but no other significant pathologic condition. From the time of the patient's admission to the hospital, sulfadiazine and penicillin were administered in therapeutic dosages without changes in the clinical picture.

A tentative diagnosis of Rocky Mountain spotted fever was made on August 19, when the patient developed an old-rose, maculo-papular eruption on the wrists and in the regions of the ankles. The lesions were approximately 1.5 millimeters in diameter, discrete, and did not disappear on pressure. A history of tick bite could not be obtained from the relatives, and the patient was stuporous and unable to concentrate. On August 21, 1945, agglutinations for B. proteus OX-19 were found positive in 1:320 dilution. A specimen taken August 22, 1945, showed a positive reaction 1:10,240 by the Michigan State Laboratory. Simultaneously a specimen was sent to the National Health Institute at Bethesda, Maryland, and the following results were reported: Agglutinations. B. proteus OX-19 positive 1:1,280. Complement fixation tests: (1) Endemic typhus: positive 1:128; (2) Rocky Mountain spotted fever; positive 1:8,192 "or higher." With this laboratory data, and with the other clinical findings, a diagnosis of Rocky Mountain spotted fever was obviously established.

The patient's course was a very stormy one and he was on the verge of extremis for at least two weeks after the diagnosis was made. At the onset of his illness the cardiac status was satisfactory with normal heart tones, normal electrocardiogram, and an occasional extra systole. Later bradycardia developed and possible heart block. Subsequently the rate returned to normal. The spleen was palpated on August 22, 1945, but was never markedly enlarged. The rash became more generalized, and deflorescence occurred on the third day.

Therapy consisted of supportive treatment with high protetin liquids given by nasal catheter, intravenous fluids, parenteral vitamins, oxygen therapy and adrenalin in oil. The patient was given two transfusions of 500 c.c. of whole blood. He regained consciousness gradually after a period of approximately six weeks. The usual problems of emaciation, decubiti, constractures and insomnia were encountered in spite of good nursing care.

The patient was not seen again until February, 1947, just prior to his admission to the University of Michigan Hospital at Ann Arbor. At that time sequellae from Rocky Mountain spotted fever were noted, viz: personality changes, partial paraplegia with contractures, decubiti, neurotrophic changes in the right hip and a reflex neurogenic bladder.

During his stay in the hospital he was given intensive physiotherapy to correct the contractures. An indwelling catheter was inserted in an attempt to favor the decubiti. He remained disoriented and occasionally became belligerent. On the morning of March 18, 1947, after pulling out his catheter, he developed generalized twitchings, became cyanotic and died. Postmortem examination did not reveal the immediate cause of death. As residue of the spotted fever, atrophy of the cerebral cortex, patchy pigmentation of the cerebrum and bilateral necrosis of the globi pallidi were noted. Microscopically, anemic infarcts, with gitter cell and astrocytic response in the white matter and basal cell ganglia, were observed. In the spinal cord there was perivascular infiltration of lymphocytes, demyelinization and gitter cell response. In the heart multiple microscopic infarcts with hemosiderin were noted, and thrombi or emboli were seen in small coronary arteries. On section, the testes showed arrested spermatogenesis, focal orchitis and fibrosa and edema.††

Discussion

Pathologically, the distinctive gross lesions of spotted fever are those resulting from the thrombosis of blood vessels, particularly the blood vessels of the skin and genitalia. In this patient there was no necrosis of the scrotum as is so frequently observed. The spleen is usually enlarged and in this patient was palpable shortly after the rash occurred. The characteristic acute microscopic pathologic condition was obviously not demonstrated at the time of the patient's death two years later. They consist of a proliferative action of the endothelium, followed by thrombosis either mural or occluding. Perivascular nodules distinctive of typhus do not develop in spotted fever.

The clinical course and laboratory findings in this case were characteristic. The *incubation period* was not known, since a history of tick bite was not obtained. The usual incubation period in severe infection is two days, and in milder ones, from three to fourteen days. The *prodromal symptoms,* chilliness, nausea, vomiting, generalized aching and malaise, were typical. The chill usually seen at the onset was not recalled by this patient. The severe headache and intense vertigo are commonly seen as the disease progresses. Deafness from other sources was ruled out by the consulting otologist.**

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Later symptoms consisting of insomnia, generalized weakness, epistaxis and a short, dry cough were typical. In the absence of demonstrable cardiac lesions, the rapid respiratory rate of 35 was out of proportion to the physical and x-ray findings, and served as a significant clue to the diagnosis. Likewise, the striking disproportion between the slow pulse and rapid respiratory rate was noted.

Central Nervous System Symptoms.—The commonly noted restlessness and insomnia constituted a most distressing feature in the management of the patient. Protean and transient neurologic findings were present. The pupils were fixed, contracted or widely dilated. Inequality of the knee jerks was noted. The cremasteric reflexes were absent. An occasional coarse tremor and an intermittent tendency toward muscular rigidity were observed. These symptoms were equivocal in establishing a diagnosis, yet their presence added to the clinical picture.

A *rash* appeared on the twelfth day of the disease and it was this finding which first served as a clue to the diagnosis of spotted fever. In view of the fact that the patient had had sulfadiazine and penicillin, rashes from these drugs also had to be considered. Nevertheless, the centripetal distribution, and the rose-red, and later bluish-red, circumscribed and sharply demarcated papules were highly suggestive of spotted fever. Not always does the exanthem partake of this characteristic picture. Discreteness does not persist in some of the cases. Purpuric manifestations frequently become apparent, and terminal gangrene, with sloughing of mucus membrane and skin, has been reported by Baker, Wolbach and others.

Laboratory Findings.—Characteristic leukocytosis with predominance of the polymorphonuclear leukocytes was present. The persistence of leukocytosis, in spite of previous chemotherapy, offered another clue to diagnosis. The consultant, seeing later stages of the disease, has the advantage of weighing the effect of such treatment even though he does not condone indiscriminate chemotherapy without diagnosis.

The positive agglutination with B. proteus OX-19 narrowed the diagnosis to spotted fever or typhus fever. In differentiating spotted fever from endemic typhus, which also gives a positive Weil-Felix test, the complement fixation test proved to be of great value.[6,33]

The clinical course in spotted fever varies considerably from mild to severe cases. In this patient the acute phase lasted from two to three weeks. The fever remained high for the first week and then fell by lysis. The damage to the central nervous system was such that the patient remained in a state of stupor for approximately six weeks, and thereafter only gradually regained consciousness. Hearing and mental acuity were definitely impaired. Through lack of co-operation, decubiti and contractures developed in spite of excellent nursing care.

Differential Diagnosis.—As previously stated, spotted fever was not considered until the characteristic rash appeared. Prior to this it was very difficult to make a differential diagnosis, but acute sinusitis with cerebral extension was considered, also bronchiectasis with brain abscess. Typhoid fever was not difficult to rule out. Purulent meningitis and meningococcic meningitis were also considered and eliminated as a possible diagnosis. Acute trichinosis was ruled out by the blood picture.

Once the diagnosis of spotted fever was entertained, differentiation from other rickettsial diseases was not difficult. Tsutsugamushi and Q fever do not agglutinate the OX-19 strain of B. proteus. In Tsutsugamushi fever there is a distinctive eschar at the site of the mite bite. This primary lesion runs through the stages of papule, vesico-papule, excoriated papule, frank escar, and finally a small scar.[1] This evolution takes place in about four weeks. Such a lesion was not present in this patient. In Q fever there is usually an absence of the rash, and chest x-rays usually show evidence of broncho-pneumonia or pneumonitis. In typhus fever the rash is more generalized, and lacks the centripetal distribution observed here. However, clinical differentiation from typhus had to be confirmed by the complement fixation test. as was done in this case.

Treatment

The treatment in this case was entirely supportive. Intravenous fluids were given sufficient to enable the patient to put out between 700 and 1,000 c.c. of urine in twenty-four hours. There is considerable controversy as to the use of intravenous fluids, but the pathological-physiological considerations of Harrell, Venning and Wolff[17] seem to favor this type of supportive therapy. As

previously noted, whole blood was given on two occasions and, because of a generalized edema, 20 per cent glucose solution was given subsequent to the transfusions. It was believed that the edema was due to loss of protein, and that the combination of blood and glucose tended to restore normal physiology.

Treatment with specific anti-serum derived from rabbits was considered and the serum was sent for immediately after the diagnosis was made. When it finally arrived, the patient had shown some clinical improvement and it was not given. As in the case of other specific anti-serum therapy, it must be administered as early as possible in the course of the disease, and little benefit could have resulted from its use at this late stage.[35]

Para-aminobenzoic acid (PABA), now the drug of choice, was not used. Snyder, Maier and Anderson[27] were the first to show its effectiveness in experimental murine typhus in white mice. Hamilton, Plotz and Smadel[16] found that the drug inhibited the growth of epidemic and murine typhus in a developing hen's egg. Greiff, Pinkerton and Morageus[15] independently noted the same effects. Yeomans[40] and his associates in 1944 favorably modified the clinical course of twenty louse-borne typhus patients as compared with forty-four untreated controls.

In June, 1945, Anigstein and Bader[2] reported the effectiveness of PABA in guinea pigs infected with spotted fever. The available literature at the time when this patient was observed contained no reference to its use in human beings. Subsequently, its use for the treatment of spotted fever has been extensively reported. The first use of PABA in clinical spotted fever was by Rose, Duane and Fichel[24] in December, 1945, four months after the occurrence of the case under discussion. Favorable results were suggested by the use of the drug in his case study. Flinn, Howard and Todd[11] reported ten cases of Rocky Mountain spotted fever treated with PABA and compared them with twenty-one controlled cases. They concluded, "most of the patients showed dramatic clinical improvement." Other isolated cases have been treated with apparent success.[18] Greely[14] has reviewed the treatment of spotted fever in children and has found that children tolerate PABA very well and that it is certainly the drug of choice.

In May, 1946, Tierney[31] reported eighteen patients with Tsutsugamushi disease treated with PABA and compared these with sixteen controls. The treated group was benefited both from the standpoint of morbidity and mortality. During the recent epidemic of Q fever in Amarillo, Texas, as well as during the outbreak of Q fever at the National Institute of Health, it is noteworthy that the drug was not used, probably because most of the diagnoses were made in retrospect. It will be interesting to observe the effect of PABA when administered early in the course of Q fever.

There is unanimity that PABA does not exert a lethal action on the rickettsiae but interferes in some way with their multiplication in tissue cells. Yeomans' most recent observations[28] should be referred to when the drug is used. In general, it can be said that early administration of the drug is necessary before the damage to the vessels is too extensive. An initial dose of 4 to 6 grams is usually given, followed by 2 to 3 grams every two hours, day and night, and blood levels are kept in the range of 30 to 60 milligrams per 100 cubic centimeters of blood. Occasional leukopenia develops, and if it persists, the use of the drug must be discontinued. The pH of the urine should be held at pH 7 or above by the use of sodium bicarbonate. Crystalinuria, when it occurs, is an indication for stopping treatment. The administration of PABA should be continued until the temperature has been normal for at least forty-eight hours lest a recrudescence of the disease be encountered.

As previously reported and as illustrated by this case, penicillin and the sulfa drugs have no specific effect on this disease.[7] The action of sulfa drugs is inhibited when used in conjunction with PABA. Penicillin is the drug of choice when secondary bacterial infection occurs and has been used successfully by Yeomans simultaneously with PABA. However, penicillin, as such, exerts no specific therapeutic action.[10]

Prophylaxis

Prophylaxis in tick-infested areas is indicated. Two or three daily inspections of the body should be sufficient in view of the fact that the invading tick crawls around from two to three hours before settling down to feed. Forceps should be used for the removal of the tick. A drop or two of kerosene, or cigarette lighter fluid, frequently facilitates its removal.

An editorial in the *Journal of the American*

Medical Association,[8] May 20, 1944, discusses the possibility that spotted fever may be prevented by injecting a minute dose of specific immune serum at the site of presumable infectious tick bites. The discussion is based on the work of Anigstein and others. A very scholarly refutation of this type of prophylaxis is presented by Armstrong and Topping[3] and should certainly be read before embarking upon its use.

Immunization of residents in Michigan is certainly not indicated unless they plan to travel in tick-infested areas. Two vaccines are available: (1) killed vaccine made from emulsion of ground-up infected wood ticks, and (2) vaccine made from rickettiae cultivated in yolk sacs of fertile hens eggs. Although immunization with either of these vaccines will not necessarily prevent the disease from developing, a marked attenuation of the symptoms will result in the event of infection.

Eradication of tick vectors may become the choice method for the control of the disease. Smith[26] found that DDT used in liquid form with pine oil as a solvent and emulsifier was effective in controlling the lone star tick and the dog tick. The thermal aerosol fog generator for large scale application of DDT has been used in New York state where spotted fever is endemic.[12,13] A considerable part of the tick population is in the egg stage, or is attached to host animals, and thus is not reached by broadcast application of DDT. It seems likely, therefore, that any effective application may have to be repeated at intervals during the season, and probably one or more succeeding seasons in order to prove effective as a control measure.

Summary

What probably will be considered the first endemic case of Rocky Mountain spotted fever in Michigan is herewith reported. It is neither wise nor practical for a clinician to remember details concerning an illness which occurs with such infrequency—what is more important is to arouse clinical suspicion because "it can happen here."

Spotted fever should be suspected in a febrile patient with leukocytosis, increased respiratory rate without objective chest findings, and protean neurologic manifestations. If in this picture the urine is negative, the spinal fluid normal, and no other localizing signs or symptoms occur, the skin should be carefully checked for a tick bite and the characteristic centripetal rash. Inquiry should be made as to the possibility of a tick bite. If this patient is seen late in his illness after penicillin and sulfa therapy has been instituted, the lack of response to therapy should serve as a further clue, even though one does not condone chemotherapy without diagnosis. If sufficient evidence exists, a specimen of clotted blood should be sent to the laboratory for agglutination with B. proteus OX-19. If these few facts are kept in mind, diagnosis ought to be made without difficulty when the disease occurs.

PABA is the drug of choice for treatment of the disease but parenteral supportive therapy, based on physiological-pathological data, should not be neglected, and penicillin rather than sulfa drugs should be used for secondary bacterial infections.

Permission for reporting this case was granted by the referring physician, Dr. Paul Hanna, St. Joseph, Michigan.

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Abdominal Surgery in Infants and Children

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DURING THE past fifteen years there has been great progress made in the surgical treatment of many abdominal lesions seen in infants and children. The progress has been the result of earlier and more accurate diagnosis, a better understanding of the fluid replacement and requirement of these young patients both preoperatively and postoperatively, refinements in surgical technique, and the use of sulfonamide derivatives, penicillin, and, of late, streptomycin. It has been said, "One can do infant's surgery on adults but not adult's surgery on infants." Judgment, the careful handling of tissues, and good hemostasis are of major surgical importance in the reduction of morbidity and mortality. The interest and co-operation of the pediatrician has contributed much to the success of the surgery of this group of patients. To be specific, without personnel capable of caring for these infants, especially the newborn, as far as supplying intravenous fluids, blood and plasma as indicated, recovery is almost impossible. Anesthesia likewise is a special problem and should be handled by one trained in this particular branch. In this brief discussion, some of the more common lesions of early infancy and childhood, as encountered in pediatric surgery, will be presented.

The Newborn

Intestinal Atresia.—In 1922, Davis and Poynter collected 392 cases of occlusive lesions of the gastrointestinal tract in the newborn, and the mortality was 100 per cent. It has been estimated that atresia occurs once in approximately 25,000 infant admissions, and the first case of duodenal atresia was described by Calder in 1733. From our experience we feel that the condition is now being recognized earlier and more frequently.

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Duodenal Atresia.—The majority of the atresias of the duodenum occur below the ampulla of Vater. Vomiting occurs usually within twenty-four to thirty-six hours after birth and is persistent after each feeding, and the vomitus is bile stained. Peristaltic waves may be seen in the upper abdomen going from left to right. There may be upper abdominal distention. Dehydration is progressive and the stools are smaller in amount. X-ray studies of the abdomen taken in the upright and inverted positions are of utmost importance in the diagnosis of atresia of the duodenum. Barium ingestion is unnecessary and dangerous for diagnostic purposes because of the possibility of aspiration and difficulty of removal before surgical intervention. Flat films will show gaseous distention of the stomach and duodenum and no gas in the remaining small bowel or colon. These lesions should be recognized early, that is, in the first two or three days of life, as after that period there is danger of impending necrosis and perforation of the distended proximal segment, with subsequent peritonitis and death. Obviously, the only chance an infant with duodenal atresia has of surviving is by surgical intervention. The mortality without operation is 100 per cent, and following operation it is still high; but through the efforts of Ladd, Miller, Horsley and others, approximately thirty successful cases have been reported. A posterior gastroenterostomy was done on one of our patients successfully. The type of sidetracking procedure will depend on the site of obstruction in the duodenum. When the atresia is above the ampulla of Vater, a posterior gastroenterostomy is preferable. If the atresia is below the ampulla, a duodenojejunostomy, either antecolic or transmescolic, is the most physiological but is not always technically possible in the occasional case. Technically, the anastomosis is not easy because the collapsed jejunum distal to the obstruction is about the size of a pencil, but it can be distended with air, which is of great help in placing the posterior row of sutures. Five 0 silk with atraumatic needles is preferable, using two rows posteriorly and a Connell suture anteriorly.

Atresia of Jejunum and Ileum.—The symptoms of atresia of the jejunum and ileum are very similar to those described for atresia of the duodenum but there is a tendency for greater abdominal distention. X-ray films of the abdomen in the upright and inverted positions will show marked dilatation of the proximal loop. In the

inverted position one will find only a small amount of air in the stomach as a separate air pocket, which is of great help in the differential diagnosis of duodenal atresia and that of the jejunum and ileum. The x-ray findings are simulated by meconium ileus. Recoveries following side-to-side anastomosis for jejunal or ileal atresia have been few because of peritonitis, but with streptomycin available, the prognosis may be improved.

Omphalocele.—This is a rare malformation in which there is abdominal viscera in the umbilical cord. The organs are covered by peritonium as a thin layer, and external to this is the amniotic membrane. These two structures are usually fused and transparent. When only small bowel is in the pouch, the opening or defect in the wall is small, making the prognosis good after surgical intervention. In the large omphalocele which contains liver and other viscera, the prognosis is much less favorable. This is a condition which demands surgical intervention as early as possible because of the risk of rupture of the thin sac and peritonitis. In other words, operative correction should be carried out within a few hours after birth. In the smaller defects, primary closure of the defect can be done in one stage after replacement of the viscera and resection of the sac. With those in whom there is a wide defect containing the liver, the primary operation consists of replacing the viscera, resecting the sac and closure of the skin. If primary repair of the wall is attempted under tension, these infants will succumb rapidly from respiratory embarrassment. The second stage of repair of the abdominal wall is postponed for a week or longer to allow the muscles and fascia to stretch so that closure can be accomplished without tension or respiratory embarrassment.

Pyloric Stenosis.—This congenital anomaly makes its presence known by the infant vomiting, which usually starts during the second to third week of life. It becomes projectile, and large peristaltic waves may be seen going from left to right in the upper abdomen after feedings. The stool is scant and dry. These patients lose weight rapidly if the stenosis is marked. A firm tumor can be palpated in the region of the pylorus in the vast majority of cases. X-ray examination after a barium meal is rarely necessary to make the diagnosis but can be used in the borderline case to determine how much retention exists. Once the diagnosis is made, these infants should be prepared for operation by having their dehydration and chemical imbalance corrected. It is not an emergency procedure so that one to two days can be used to prepare these infants adequately for operation.

The Fredet-Ramstedt procedure is done under ether anesthesia, with complete severance of the circular muscle so that the submucosa pouts well up to the margin of the defect. Care must be taken not to perforate the duodenal mucosa. If it occurs, the perforation should be closed with a fine silk suture re-enforced by a tab of omentum. If the perforation is unrecognized, a fatal peritonitis will result.

With proper pre- and postoperative preparation, meticulous surgery, good anesthesia and isolation of these infants to minimize infections, the operative mortality can be reduced to a minimum. In the last 292 infants on the surgical service, the mortality has been two deaths or 0.7 per cent. The results of the Fredet-Ramstedt procedure are as brilliant as any surgical procedure practiced at this time.

Infants and Children

Meckel's Diverticulum.—This anomaly occurs usually in the last 30 centimeters of the ileum and deserves special consideration. Meckel's diverticulum is important because of the complications which may occur in it or because of its presence. These are: (1) massive or repeated small hemorrhages, (2) inflammation and perforation, (3) the starting point of intussusception, (4) abdominal pain, and (5) intestinal obstruction. Massive hemorrhage, usually without abdominal pain, occurs most frequently in the infant two years or younger, but we have observed it in young adults up to seventeen years of age. Hemorrhage is due to either gastric or pancreatic aberrant tissue in the Meckel's diverticulum, with ulceration and erosion of blood vessels of the mucosa of the diverticulum itself or the adjacent ileum. These patients are often in hemorrhagic shock when first seen and require transfusion before considering laparotomy. Blood can be given during the operative procedure to fortify further their general condition. Laparotomy is required for all the complications of Meckel's diverticulum. The diverticulum is excised between Kocher clamps at 45° angle to the long axis of the bowel. The bowel is closed without opening the lumen by a continuous fine chromic intestinal

suture, re-enforced by interrupted silk sutures. The purse string type of closure is to be condemned because of subsequent narrowing, partial obstruction, and occasionally perforation. The mortality is dependent on the early recognition of the complications of Meckel's diverticulum and the time of illness subsequent to operative intervention. This is particularly true when Meckel's diverticulum causes intussusception, various types of obstruction and perforation. Of fifteen cases reviewed on the surgical service the following points are of interest.

Meckel's Diverticulum

I. Recoveries—twelve.
   A. Cause of Admission to Hospital
      (a) Hemorrhage—six. Massive hemorrhage—four. All had aberrant gastric tissue in Meckel's diverticulum except one with pancreatic tissue.
      (b) Pain—four.
      (c) Umbilical Discharge—two.
   B. Attached to Umbilicus—six.
   C. Management.
      (a) Excision—nine.
      (b) Resection of ileum and Meckel's diverticulum, with anastomosis—three.

II. Deaths—three boys, in 1933-1934 before sulfa and penicillin.
   A. Eight years old. Had pain for forty hours. Ruptured Meckel's diverticulum with abscess. Died twenty-four hours after operation.
   B. Nine years old. Had pain for forty hours. Gangerous small bowel, with band. Meckel's diverticulum to umbilicus.
   C. Eleven years old. Bowel resertion and anastomosis. Died sixteenth day after operation. Intestinal obstruction.

Intussusception.—The classical symptoms are those of sudden onset of crampy abdominal pains in a previously well infant. As the obstruction progresses, the interval between pains becomes shorter and may be followed by nausea and vomiting. The first bowel movement may be normal but the subsequent one may have blood and stool mixed. The passing of a bloody stool follows, usually bright red or mixed with dark blood. Physical examination will reveal a mass in the majority of patients eight to ten hours after the onset of symptoms. The mass is described as soft, sausage-shaped, and there is usually a flaccid abdomen. When the symptoms have been present more than ten to twelve hours, fever of 100° to 101° is usual. The above group of symptoms and findings are found in the ileo-colic type, which constitutes about 75 per cent of the cases. In the ileo-ileo type no mass may be palpated, but the signs of intestinal obstruction are present and a scout film of the abdomen is helpful in the diagnosis.

An early and accurate diagnosis is of paramount importance so that surgical reduction of the intussusception can be carried out at the earliest possible moment. Patients who enter the hospital with a temperature above 101° with intussusception will show signs of toxemia, and the prognosis will be more guarded. The intussusceptions that are operated upon within twelve to eighteen hours have an excellent prognosis because they can be reduced before any bowel damage has occurred. In patients coming to operation with a high fever and symptoms of obstruction for more than twenty-four hours, the mortality is correspondingly higher. It is well to remember about 80 per cent of the cases of this lesion are seen in infants between the ages of three and eight months, and males predominate; the mortality in any given series is in direct proportion to the time from the onset of symptoms to the time of surgical intervention. Mortality in former years ranged about 50 per cent. This was because many of these patients arrived at the hospital with considerable bowel damage, many having gangrenous bowel and peritonitis. During the past few years, with earlier diagnosis and early operation, the mortality has been less than 10 per cent. In older children, when intussusception is present, it is more likely to be of the colic variety; and if there is any question about the diagnosis, a barium enema, given carefully, is indicated to establish the diagnosis. It is also important that a few hours be spent preoperatively in restoring the chemical balance in those patients who are toxic. The giving of blood during operation will help to minimize the shock that may be attendant with the surgical procedure. In those patients entering the hospital with intussusception of long duration, and which is irreducible, the prognosis is grave. Either a Mikulicz procedure or an anastomosis with excision of the mass can be done. The survivals of patients in this desperate situation are still very few, but more successful cases are being reported.

Appendicitis.—The symptoms of acute appendicitis in the child are quite typical in the majority of patients. It is to be remembered that appendi-

citis can occur in the young child under three years of age, and that perforation may occur early, that is, in six to ten hours after the onset of symptoms. The young child's appendiceal wall is thin and practically devoid of a muscular layer, so that when obstruction occurs in the lumen, followed by distention, perforation or necrosis occurs. When the history strongly suggests acute appendicitis, and the abdominal findings of tenderness and muscle guarding are absent, rectal examination is indicated to rule out a pelvic appendicitis. The morbidity and mortality associated with appendicitis in children have been reduced by the chemotherapeutic agents, in conjunction with sound surgical procedures and judgment in the management of the peritonitis group, especially. In 1942, a review of 1,653 patients with appendicitis, over a fifteen-year period (1927-1941) on the surgical service at the Children's Hospital of Michigan, listed an overall mortality of 4.2 per cent. In this group there were 94 patients with diffuse peritonitis, who had a mortality rate of 64.9 per cent. Thirty-five of these patients died without having any operation as many were practically moribund on admission. Since 1942 an additional 435 infants and children with appendicitis have been operated upon, and 104 have had peritonitis. In this entire group of 435 patients there has been no death. These patients have had the benefit of surgery, sulfa compounds and penicillin, adequate amounts of blood, plasma, glucose and salt solutions to maintain proper mineral and electrolytic balance, and intestinal intubation to minimize and control distention. In the reduction of morbidity and mortality of appendicitis, early diagnosis and operation is of prime fundamental importance.

Hernia.—Diaphragmatic hernia should be suspected in all newborns who have dyspnea, cyanosis or vomiting. X-ray examination will confirm the diagnosis, and surgical intervention is indicated in the first few days of life in all except the small esophageal hernia. These infants tolerate surgery well, and the abdominal approach is advisable.

Umbilical hernias respond to strapping in the great majority of infants during the first year of life; after this period, those who do not respond to adhesive strapping will require surgical repair. Incarceration in this type of hernia rarely occurs under a year, but when it does, surgical intervention is indicated.

Inguinal hernias are frequent, and incarceration under the age of two is not infrequent. Since 1941, thirty-eight infants under two years of age have been operated upon for incarcerated hernia, and ninety-seven operated upon as elective procedures because of pain, repeated occurrences of mild incarcerations, or large hernia which interfered with the child's normal activities. There has been no operative mortality in this group. It has been a policy in past years to postpone elective surgery for hernia in infants until after the age of two years or more. It is our feeling now that if the indications are present for surgical correction, age is not such an important factor as formerly believed. The repair used in children and infants is that of the Ferguson operation with non-transplantation of the cord. The congenital indirect sac should be carefully separated from the cord structure, so as not to injure the small blood vessels, vas deferens and nerves. Complete surgical excision of the sac following high ligation is followed by excellent results. Recurrence is a rarity.

Summary and Conclusions

1. A brief discussion of some of the lesions of the abdomen in infants and children requiring surgical intervention has been presented.

2. The reduction of morbidity and mortality in abdominal surgery of infants and children has been possible because of (a) better understanding and evaluation of the fluid and chemical requirements both preoperatively and postoperatively, (b) earlier and more accurate diagnosis, (c) improved surgical technique and anesthesia, and (d) chemotherapy.

3. The active co-operation of the pediatrician and surgeon in these problems is necessary to obtain the most satisfactory results.

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MSMS

One of the purposes of a medical service plan is to bring prepaid medical care to the majority of the people. This is done by enrolling small groups of five employes.

The Physician and the Child

By Reynold A. Jensen, M.D.
Minneapolis, Minnesota



THE PHYSICIAN'S interest in the child is a comparatively recent development in medical practice. In 1880 a special Section of Pediatrics was organized in the American Medical Association, and eight years later the American Pediatric Society was founded. While an increasing number of physicians had begun to devote themselves to children's medical problems prior to that time, these two organizations gave impetus to this interest and placed the newly developing specialty on a sound basis. In general, the three most pressing problems were those of (1) physical growth and development, (2) the infectious diseases, and (3) the nutritional disorders.

Looking back today, we are all heartened by the progress which has been made. Infant feeding and nutrition are on a sounder basis, markedly decreasing the nutritional disorders of childhood. Many of the infectious diseases have been reduced both in number and severity. Improved newborn care has reduced infant mortality substantially; the advances in physiological knowledge have made possible supportive therapy as needed, and recently, the use of the sulfa drugs, penicillin and other antibiotic drugs has contributed much to the improvement of the physical health of our children.

Encouraging as this progress is, there are many problems yet to be solved—rheumatic heart disease, the virus diseases, ulcerative colitis, enuresis, and encopresis, to name only a few. In addition, an increasing number of children come to us with physical complaints not substantiated by organic findings, or with vague complaints which are not related to physical illness. The so-called "behavior problem" child is always with us. It is these latter two groups that I should like to consider in this discussion. Almost every one of us, regardless of our specialty interest, has encountered such children in our practice. The management of these difficult cases taxes our skill and patience to the utmost. There is scarcely a one of us who, after giving his best, has not in final desperation suggested that "maybe he will grow out of it." However, there is accumulating evidence to show that too many of these children do not grow out of it, but become progressively more difficult problems to themselves, their families, society in general, and too often to the physician himself. The vast army of psychoneurotic adults in our country is ample testimony to this statement.

In illustration, permit me to review briefly a few typical cases which have come to our attention.

Case Reports

Case 1.—M. J., a six-year-old girl, the youngest of a family of four children, the others being boys, suddenly became blind during a mild attack of the measles. The blindness persisted following recovery from the measles. The family physician and several consultants failed to establish a diagnosis or help the patient therapeutically. One consultant made a tentative diagnosis of retro-bulbar neuritis—"just to make sure."

One month following recovery from the measles the patient was referred to our hospital. Our physical studies were essentially negative. However, we noted some important facts previously overlooked. Our patient bore the brunt of an intense sibling rivalry in the home. The parents, active in an organization for the blind, were out of the home many evenings, leaving the girl in the care of her brothers. Through this organization our patient had met and come to admire greatly a blind woman.

With these facts established, it was possible finally to help our patient and the family understand the problem. Quite unconsciously, she had resorted to blindness to escape the difficulties with her siblings and gain for herself a place of security in the family. Within a month she recovered fully, and has remained free from symptoms for over three years. The final diagnosis in this case was conversion hysteria.

Case 2.—L., a fifteen-year-old boy, the oldest of a family of four children, had had terrific headaches and vague abdominal complaints for several years. All physical studies, including our own, were negative. However, in the course of our study, we found he suffered from a specific reading disability which resulted in an overwhelming fear of failure in school. Interpretation of his basic difficulty to him and his family, together with some adjustments in the school, resulted in marked relief from symptoms.

Case 3.—T., a fifteen-month-old girl, the older of dissimilar twins, weighed no more than she did at six months of age. Repeated comprehensive physical and laboratory studies revealed nothing suggestive as to etiology. Investigation brought out the fact that the children were

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born during the father's period of military service. The mother, anxious and high strung because of the father's absence from home and the tensions growing out of living with relatives, found herself unable to continue nursing both children. Upon a physician's advice, the patient was removed from her mother's breast and the twin brother kept on it. The feeding problem began concomitantly with removal from the breast.

Several interviews with the parents helped them to understand and manage the patient more effectively, and she showed considerable improvement. However, she continues to be very hostile toward her twin brother.

Case 4.—J., a nine-year-old girl, had suffered from bronchial asthma for five years in spite of active treatment. Nothing was effective. After a prolonged period of intensive work with the family, it was learned that her difficulty followed the witnessing of the death of a younger sister who had choked to death in the mother's arms during a severe paroxysm when ill with pertussis. From this point on, the mother became extremely oversolicitous of our patient.

The patient improved considerably following clarification of her psychological troubles and restoration of a more normal interpersonal relationship with her mother, but five long years had elapsed.

Case 5.—H., a nine-year-old boy, was referred to our hospital because he was failing in school, had begun to steal (always from his own mother), was becoming increasingly difficult to manage at home, and occasionally would remain away from home for several days. He "liked to stay over to the neighbors."

Our physical studies were negative. His psychological examination indicated he was of good intellectual capacity and could manage his school assignments satisfactorily.

The basis of the problem finally was reached when the mother candidly acknowledged she "had never wanted him." The family were farmers and had purchased a tractor at about the time the mother became pregnant with our patient. Having the baby was an additional expense just at the time that the tractor had to be paid for.

Our efforts to modify the mother's attitude toward this lad were not fruitful. However, his behavior improved following a series of interviews with him, during which he had a chance to "get a lot of things off my chest." With our support, the father was able to deal more understandingly with the boy and helped him considerably.

In each of the above illustrations, the chief source of difficulty was a severe emotional problem. When the problem was recognized and simple steps were taken to help both parents and child deal more effectively with it, improvement followed.

The number of children suffering from such problems is greater than has been appreciated. No accurate figures are available as far as is known. However, it has been estimated that nearly one-third of all children in our country under five years of age, or approximately five million, have problems of eating, sleeping, elimination, temper tantrums or nervousness. This may be the reservoir from which later problems arise. It is estimated that over one million children have speech difficulties such as stammering. There are many theories regarding the etiology of this disagreeable handicap; one now gaining favor is that a severe emotional problem is involved. Approximately 10 to 20 per cent of our school children cannot read, due either to poor teaching techniques or to a specific learning disability. Another problem is limited intellectual capacity, which makes it difficult for some children to meet the competition of others satisfactorily. We have no adequate figures on juvenile delinquency, but we know the so-called "neurotic delinquent" is frequently encountered. Some years ago it was estimated that of the 2,020,000 children in the public schools of New York City, 95,000 could expect to spend part of their lives in a mental hospital. In a recent issue of one of the national weekly news magazines, it was reported that each year thirty or more of our children under ten years of age commit suicide, a problem not generally recognized.

Anxiety

One of the most important emotional states encountered is that of anxiety. Simply defined, anxiety is an unpleasant-feeling state which usually develops whenever the child is not sure of his relationships to those upon whom he is dependent. Anything real or imaginary which threatens the infant's or child's sense of belonging completely and intimately to his mother initially, and later to his parents, will produce it. While it is closely related to fear, it differs from fear in that there is no apparent threat from external circumstances.

It is difficult to conceive of anyone, young or old, not being subjected to periods of emotional stress and strain—at least as our present world is organized. However, like the adult, the child is capable of handling stresses and strains if they are not too severe or too long sustained. It is only when emotional tension is prolonged beyond the limits of tolerance that it becomes overwhelming.

When it reaches these proportions, the child, unable to handle his tensions satisfactorily, may seek

relief in one of several ways. He may become a "problem child," hard to manage because of temper tantrums or rages. He may become overactive, a hyperkinetic child. He may become destructive and display periodic outbursts of negativism. He may withdraw within himself to become shy and inhibited. He may become so withdrawn as to create the impression of extreme mental retardation. He may exaggerate his symptoms when ill. Excessive anxiety disturbs the equilibrium of one or more of the body systems. Muscle tension may be increased. Respiration and heart beat may be accelerated. The activity of the gastrointestinal and genitourinary system may be altered—to mention only a few. He may even develop a definite neurosis, such as hysteria or an anxiety state.

The sources of tension producing anxiety in children are many and varied. In the infant, anxiety may be related directly to the nervousness and anxiety of the mother, which is communicated to the child by means little understood. It may be due to unreasonable and excessive demands made upon him, such as too rigid adherence to feeding schedules without allowing for individual variations in need for food. Bowel and bladder training, when begun too early and carried on too persistently before the child is ready to assume such responsibility, may cause trouble. An attitude of oversolicitude and protectiveness, which does not permit him to exercise his own initiative when he is ready for it, may produce anxiety.

In the older child, parental friction, whatever its source, is an important factor. Real or imagined lack of parental affection destroys the child's sense of belonging and may be another cause of tension. This often follows the birth of another child into the family, particularly if the new arrival comes unexpectedly. The feeling of not being wanted because of parental preference for other siblings is often encountered. The inability to compete successfully with contemporaries in the neighborhood or school may threaten the child's security. Unusual circumstances, such as an illness or death of a loved one or being involved in forbidden activities, may produce excessive anxiety. Many other sources could be mentioned.

Emotional Factors

It is often difficult to evaluate the relative importance of a disturbed emotional state in a patient situation. However, if we are willing to accept the fact that emotional factors must be considered along with others, and if we are willing to inquire about them, we will often find helpful clues. Our own attitude toward the total situation should be one of interest, willingness to try to understand, and willingness to *listen*. Such an attitude invites co-operation and promotes mutual confidence so essential in the process. A critical, blaming or punitive attitude invites failure, for it destroys the patient's and parents' ability to share their thoughts and feelings easily and fully with us.

An understanding attitude on the part of the physician often results in the initial complaint being expanded into many, and sources of tension usually manifest themselves. Careful inquiry not only into the historical account of the problem but also into the feeling states accompanying the various phases of its development, is helpful. In this sense the pregnancy, labor, birth, health and developmental history of the child, his eating, sleeping and elimination habits, the home circumstances, relationships and attitudes—important in themselves—take on added significance as they gradually reveal the total setting in which the child lives. An analysis of the child's ability to compete successfully with others, particularly after he has entered school, together with his play interests and the character of his play, is another guide.

The absence of any conclusive physical findings helps to substantiate the importance of emotional tension. In no instance should a thorough physical examination be omitted. In an extremely difficult situation, a few days' observation in a hospital away from the family is recommended.

Following such a procedure, it is possible to evaluate the relative importance of the emotional and physical factors in any case and to give proper emphasis to each in management. It may be that time must be spent helping parents toward a better understanding of the child's total needs. Certainly this is true in the case of younger children. It may be that the child himself will, with encouragement, gradually tell us his side of the story and profit by the realization that here is someone who understands. We may need to help the family and the school adjust the school program to meet the child's needs.

(Continued on Page 200)

Thirty Years of Progress in Obstetrics

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WHEN ONE speaks of progress in this rapidly changing world, he thinks only of the improvements which have taken place and does not take into consideration the many setbacks which have occurred. Fortunately, two World Wars, the threat of socialized medicine, and the many economic problems which have threatened our entire social structure, have not deterred the practicing physician from his endeavor to alleviate the physical ills of our population. Our course has been set and we have not, even on the darkest night or in the most turbulent waters, deviated from it.

I have been asked many times why I chose the field of obstetrics as my life's work. I have never answered this question publicly before, but in this communicaton I am going to admit that thirty years ago, after having served a rotating internship of thirty months, having been exposed to all of the various branches and specialties of medicine, being somewhat immature and at that time having altruistic ideas, I decided that obstetrics as a specialty occupied the lowest rung of the ladder. With prenatal care in its infancy and maternal mortality accepted as part of the price of motherhood, the poor lowly obstetrician was frowned upon by that almighty personage the general surgeon, accepted as a necessary evil by most hospital administrators, and pushed into unwanted space with the admonition that women had always had babies and would probably continue to have them.

I well remember the many sage prognostications of my venerable chief, Dr. Edward P. Davis, with regard to obstetric practice. One was to the effect that, to be truly an obstetric specialist, one would have to be a trained abdominal surgeon, because gynecology, instead of being a specialty of its own or the bread and butter of the general surgeon, was in reality the handmaiden of obstetrics. Fortunately, I have lived to see this prognostication come true. Although there are many competent obstetricians who have not been trained in gynecologic surgery, a vast proportion of specialists have been, and as a result are better able to handle complicated obstetrics. During this same period of time, the general practitioner, who after all remains the keystone of obstetric practice, has learned not to enter where angels fear to tread, and does not hesitate to call in a competent consultant when available. One of the foremost questions in my mind over this period of years has been, why should a general practitioner attempt a difficult version or forceps delivery when he wouldn't think of taking out an appendix, the former being in many instances a much more formidable proceeding, maybe not resulting in mortality but often resulting in permanent crippling invaldism. If one is to practice good obstetrics, it is necessary to bring the patient to the point of labor in the best possible physical condition, to obtain for her a living child, and to return her to society in as good physical condition as she was before becoming pregnant. This should be the goal of every doctor who undertakes the management of the parturient woman.

The picture of obstetric practice thirty years ago was slightly different than it is today. Thirty-two years ago, when I began my hospital residency, Europe was in the throes of that great conflagration known as World War I, the Democrats were promising to keep us out of war, a five-cent cigar was still obtainable, and the price of an evening's entertainment was within the reach of the pocketbook of even the unpaid intern. When a woman became pregnant, she usually registered at a clinic at about the seventh month of her pregnancy. If she went to a private physician, she told him when she expected her baby, was advised to call him when in active labor, and if she submitted a specimen of her urine, it was usually given that well known "sun and sink" test (holding it up to the sun and dumping it in the sink). Our maternity ward always had two or three critically ill women who, because of an unsuccessful attempt at delivery outside, were subjected to the Porro operation, in which the stump of the uterus was sutured outside the abdominal incision; and one could always demonstrate a woman with "fits."

Common custom ordained that all patients delivered by forceps or version, and all cases of twin

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pregnancy or polyhydramnios, should have the placenta removed manually, following which an intra-uterine douche of one-half per cent lysol was given, the uterus packed with iodoform gauze and the vagina packed with bichloride gauze. The operation of cesarean section was a dramatic affair; all were classical unless the uterus was removed, during which time a stop-watch was held on the operator and the operation performed under deep ether anesthesia, with resultant laborious efforts to make the baby breathe. My chief's explanation of the baby's difficulty to breathe was that the baby hesistated because he was put off at the wrong station in the middle of the night. The uterus was removed from the abdomen before the child was extracted, necessitating an incision from the symphysis pubis almost to the ensiform. The umbilicus was removed because "they weren't wearing them then." All patients received an intravenous administration of saline and a thorough gastric lavage under anesthesia, providing the tube didn't get into the air passage by mistake.

Many vaginal examinations were made, although with care, during the course of labor. Care was taken never to rupture the membranes because this would result in a "dry labor." Vaginal delivery was, if possible, always spontaneous, with the patient on her side and a sand bag separating her legs. She was relieved of her pain by a not too generous whiff of chloroform or ether. Episiotomy was not done and repair of lacerations was accomplished by through and through sutures of silkworm gut, sometimes with anesthesia but mostly with analgesia. The use of morphine during late labor resulted in many narcotized babies. The lying-in period was fourteen to twenty-one days, during which time the patient was kept absolutely quiet and in semi-fowler position. If the uterus was packed, another intra-uterine douche was given at the end of forty-eight hours when the packing was removed.

Oxytocic drugs consisted of one teaspoonful of fluid extract of ergot, repeated occasionally. Manual dilatation of the cervix, the use of the Voorhees bag, and Dührssen's incision were common practice.

Toxemia of pregnancy was attacked from an elimination standpoint, so that purging, bloodletting, sweating, and the use of leeches supposedly got rid of the poison. Cesarean section was performed almost routinely on the eclamptic before the toxemia was treated.

Puerperal sepsis was on the way out, but the occurrence of postpartum hemorrhage, thrombophlebitis, embolism, and the breaking down of perineii, was an everyday incident.

This is only part of the picture of obstetric practice as I recall it thirty years ago. Time does not permit me to elaborate on this, and I shall proceed to discuss a few of the improvements that have occurred during my active professional career.

Prenatal Care

Education of the laity as to what constitutes good prenatal care has resulted in women going to their doctor or clinic early in pregnancy and following the advice received. Education of the doctor and the improved methods of teaching obstetrics have resulted in the patient's being examined more thoroughly and receiving more detailed instruction. This combination has reduced maternal mortality and has saved many babies. Most women know that if the patient doesn't have a complete physical examination, Wassermann test, blood count, Rh factor determination, urine analysis, careful check on weight and blood pressure, detailed instruction as to diet, rest, exercise, sexual relations, and isn't sent to her dentist, she is not receiving adequate prenatal care. This should also include pelvimetry and at least one careful vaginal examination.

We believe today that nutrition in pregnancy is one of the most important factors in the prevention of toxemia, anemia, prematurity, and many of the common discomforts of pregnancy. Before the outbreak of World War II, we studied 2,000 patients. Of this number, 593 were studied in statistical detail and compared to a comparable group of 772 control patients. The control group was composed of ward patients taken from 1939 and consisted of all white patients having viable births. The research group of 593 was established on the same basis. Our statistical findings were as follows:

	Control Group	*Research Group*
Total baby deaths	18 (2.33%)	11 (1.85%)
Stillbirths	9 (1.16%)	5 (0.84%)
Neonatal Deaths	9 (1.16%)	6 (1.01%)
Prematurity (5½ pounds or less)	54 (7.07%)	24 (4.16%)

The Control Group represents a 70 per cent increase in incidence over the Research Group,

or a 41.2 per cent decrease in incidence in the Research Group.

As a result of this study we are now starting a five-year period of research along the same lines but with a much more thorough investigation, particularly from the laboratory standpoint. During this research period, we hope to gather sufficient valuable information to place the subject of nutrition in pregnancy on a permanent firm foundation. At the present time we are using a diet consisting of 120 to 125 grams of protein, 85 to 90 grams of fat, and approximately 275 grams of carbohydrate, or sufficient to make approximately 2,300 calories. This diet also contains the minimum daily requirement of the known vitamins and minerals. This diet was established on a pregravid weight of 110 to 120 pounds and is adjusted to the individual patient according to her pregravid weight. We are also very much interested in preoperative and postoperative diet and the maintenance of fluid balance during labor.

The diagnosis of "false pregnancy" is seldom made since the introduction of the hormonal tests of pregnancy.

X-ray is of great help in confirming the clinical diagnosis of pregnancy but is of more value in the study of the relationship of the size of the baby to the maternal pelvis. It also is an aid in the diagnosing of multiple pregnancy, intra-uterine fetal death, the presence of monstrosities, and visualization of the placenta. Thus the laboratory and x-ray departments have become an integral part of obstetric practice.

The incidence of toxemia of pregnancy has decreased with the institution of better prenatal care and its early recognition and treatment.

The prevention of abortion has had and is still having very thorough investigation. The use of hormones, vitamin E, and good prenatal care has brought happiness to many women by giving them a living child, even after repeated miscarriages. The management of threatened and incomplete abortion is still being argued between the radicals and conservatives. We lean to conservatism and do not enter the uterine cavity without a definite indication, which is usually bleeding.

Much is still to be learned about the Rh factor problem. In suspicious erythroblastotics, immediate transfusion of Rh-negative blood to babies born of Rh-negative mothers, has saved many of these babies. However, until such time as we have the answer as to what to do for the mother to prevent this condition occurring in the baby, we shall have to go on wondering about the outcome. I do not favor cesarean section prematurely, as in the few instances when I was swayed to do this, I have had a premature baby on my hands who in all likelihood would have been normal if carried to full term.

The early recognition of placenta previa and premature separation, the more frequent use of cesarean section, and transfusions have decreased the mortality for both mother and baby. We do not believe in employing cesarean section as a routine, but an analysis of our results makes us feel that it should be used more frequently. Our last survey at the Philadelphia Lying-in Hospital covered the period from 1934 to 1945 and was made by my associate, Dr. Robert Kimbrough. The findings were as follows: Premature separation of the normally implanted placenta and placenta previa account for approximately 6 per cent of all maternal deaths throughout the country attributable to childbirth. In 28,288 deliveries in our clinic, there were 113 cases of abruptio, an incidence of one in 250. Toxemia of late pregnancy was the etiological factor in 48 per cent of the cases; 52 per cent were unknown. There were sixty-six cesarean sections (58 per cent) and forty-seven vaginal deliveries (42 per cent). There were two maternal deaths, an incidence of 1.8 per cent; one occurred following cesarean section and one following vaginal delivery. The latter death was attributed to acute yellow atrophy. In the 113 cases of abruptio, there were thirty-nine fetal deaths (nineteen stillborn and twenty neonatal), an incidence of 35 per cent. Nineteen of the thirty-nine dead babies weighed less than 4 pounds, giving a corrected fetal mortality of 21 per cent. In the same series of deliveries there were ninety-two cases of placenta previa, an incidence of one in 307. The marginal type, in which the placenta covered only a portion of the internal os, was most frequently encountered; next in order of frequency were lateral and central implantations. Vaginal delivery was performed in 19 per cent and cesarean section in 81 per cent. There were two maternal deaths or 2.2 per cent. There were no maternal deaths following vaginal delivery but unfortunately a relatively small number of patients were found amenable to simple procedures. In the ninety-two cases of placenta previa there were twenty-four fetal deaths, an in-

cidence of 26 per cent. Nine of the twenty-four dead babies weighed less than four pounds, giving a corrected fetal mortality of 18.5 per cent.

Management of Labor

Great strides forward have been made in the management of the patient in labor. The maintenance of fluid balance, more rigid observation, and the relief of pain have decreased the fear of this ordeal. We usually make one careful sterile vaginal examination on admission to the labor room and then follow the course of labor by rectal palpation. There is no such thing as a routine method of pain relief. Every patient must be individualized and one of the many methods instituted. The relief of pain begins at the first prenatal visit, and although Grantley Read has proved the great benefit of the relief of fear, I feel it should be used as an adjunct to other proper methods. More and more we are resorting to some form of regional block and less to inhalation anesthesia. We use very little morphine, and, if sedation is decided upon, we use a combination of amytal, seconal, and scopolamine, terminating the delivery under nitrous oxide and oxygen. We are firm believers in prophylactic outlet forceps with episiotomy, and never allow the head to remain on the pelvic floor more than one hour with no progress. Ergotrate and pitocin are given after delivery. The ergotrate is routinely given intramuscularly but if immediate contraction of the uterus does not occur, a second ampule is given intravenously. Pitocin is a wonderful drug, but we do not employ it very frequently to induce labor, much preferring castor oil and an enema. If this is not successful, we then rupture the membranes.

Cesarean Section

With the development of the low flap and extra-peritoneal operation, the improvement in cesarean section technique now allows us to give the patient a test of labor or even to operate upon her when the uterus is potentially infected, without sacrificing the uterus.

Choice of anesthesia is just as important as the selection of the type of operation to be done. We have now performed 786 cesarean sections of various types under fractional spinal anesthesia without a maternal death. After seeing the relaxation of the abdominal wall, the absence of need for resuscitation of the baby, the reduced blood loss with good uterine contraction, the speedy and easy convalescence of the mother, and her appreciation of hearing her baby's first cry, I am convinced that the use of general anesthesia will be replaced by some form of regional block.

Pyelitis, infected abortion, mastitis, and other infections usually respond to the sulfonamides or penicillin.

In many instances early ambulation has prevented thrombophlebitis. It also allows the patient to regain her strength more rapidly and gives her early self-assurance.

Conclusion

As I compare obstetric practice today with that of thirty years ago, I cannot help but feel that tremendous improvement has occurred. Utopia has not been reached. After all, we are just ordinary human beings trying to help Nature improve and preserve mankind, struggling at times under great odds but always looking for any avenue which might open the way to further improvement. This is as it should be. We would not be keeping faith with our fellow man, nor would we be keeping the trust imposed on us as physicians, if we did not seek improvement.

In conclusion, I should like to enumerate some of the problems that need further thought and study: nutrition in pregnancy, the cause and treatment of toxemia, the Rh factor, analgesia and anesthesia, the prevention of prematurity and abortion, the prevention of monstrosities, and the management of pregnancy complicated by diabetes, cardiac disease, and renal disease.

Finally, there is no specialty in medicine where there can be a routine procedure for the management of its complications. There is no other specialty where individualization is of such paramount importance. Always remember, to be a good obstetrician you must first be a good doctor.

MSMS

EASTER SEALS

(Continued from Page 146)

Each doctor of medicine can serve his community and his profession by buying and encouraging the sale of Easter Seals. It's a grand opportunity to give, and know that your gift means a chance for a crippled child to be restored to health.

You are invited to write the Michigan Society for Crippled Children and Disabled Adults, Inc., 449 W. Ferry Avenue, Detroit 2, for detailed information on any of its many activities.

Detroit Physiological Society

Session of November 20, 1947

The Effect of Certain Nitrogenous Compounds on the Production of Polycythemia by Cobalt. Mary C. Bucciero and James M. Orten, Department of Physiological Chemistry, Wayne University College of Medicine.

A study has been made to obtain information on the mode of action of cobalt in stimulating hemopoiesis. Groups of rats were fed an adequate synthetic basal diet supplemented with small amounts of cobalt and with cobalt in combination with choline, methionine, histidine or cysteine. A group of unsupplemented animals served as controls. Body weight and food consumption were followed weekly and hemoglobin determinations made biweekly.

The rats administered cobalt grew at a decreased rate but consumed more food per 100 grams body weight than did the control animals. The average hemoglobin value reached a level of 20 grams per 100 ml. of blood.

The administration of choline with cobalt resulted in a retardation of growth and the development of a polycythemia, both to the same extent as in rats given cobalt alone. All the values obtained on these two rats paralleled very closely the results obtained in animals administered cobalt alone.

In rats fed methionine with cobalt there was a definite beneficial effect on body growth but no alteration in the rate or extent of hemoglobin formation as compared with animals given cobalt alone.

The animals which received histidine in addition to cobalt showed evidence of some effect on the inhibition of growth produced by cobalt, but the reduction in the hemoglobin value to an average of 18.2 was more significant.

The most striking results were obtained in animals receiving cysteine with cobalt. In this group, there was a significant increase in body weight as compared with the animals administered cobalt alone. There was also a negation of the polycythemia as indicated by an average terminal hemoglobin value of 17.3 grams per 100 ml. of blood. This effect of cysteine is highly significant as borne out by a statistical analysis of the data.

The foregoing observations suggest that the factors governing the rate of growth and those involved in increasing the level of hemoglobin under the present experimental conditions are probably not the same.

Two additional groups of rats were studied in order to determine whether the mode of action involved in the inhibition of the polycythemia by cysteine and histidine was one of decreasing the absorption of cobalt from the gastrointestinal tract. Control rats injected with cobalt sulfate developed a polycythemia whereas rats injected with the cobalt-cysteine complex in an equivalent amount did not show any increase in the hemoglobin level above that of normal rats. These data thus indicate that a possible impairment of cobalt absorption from the gastrointestinal tract by cysteine is not the critical factor.

Two explanations of the effect of cysteine and histidine in preventing the production of polycythemia by cobalt appear possible. One is that these two substances by forming complex compounds with cobalt may increase its excretion and thus decrease its ability to produce a polycythemia. The other explanation, the more likely in our opinion, is that the administered cysteine and histidine combine with cobalt in the tissues thus preventing its subsequent "blocking" of sulfhydryl and perhaps other groups active in cellular respiration and thus, in turn, preventing the development of a compensatory polycythemia.

An Oxyhemograph: A Continuous Method for Measuring the Percentage of Oxygen Saturation of the Blood. F. W. Hartman, V. G. Behrmann, Henry Ford Hospital, and F. W. Chapman, General Motors Research Laboratories.

The demand for a reliable procedure for continuously recording the oxygen saturation of the blood has led to the publication of several photoelectric methods (Nicolai, 1931; Kramer, 1934, 1935; Matthes, 1934, 1935; Hartman & McClure, 1940; Squire, 1940; Goldie, 1942; and Millikan, 1942). The merits of these techniques are discussed and the improvements, incorporated in the oxyhemograph, are described. The blood oxygen saturation is measured by means of a bichromatic

photocell, secured to the helix of the ear, a unique feature of the method being the amplification by means of a "contact modulated" D. C. amplifier, which is both stable and sensitive and allows a permanent continuous record on a rugged D. C. milliameter.

Calibration data are shown which correlate actual arterial blood oxygen saturation values with the oxyhemograph readings. The arterial blood was analyzed in duplicate for oxygen content and oxygen capacity using Van Slyke's manometric method. The data obtained on twenty clinical cases show that the chemical and instrumental data are usually within ± 2½ per cent. The calibration of the instrument for use in the experimental animal is complicated by breed variations within the species. Therefore, the conformity of the blood analyses and the oxyhemograph values is less precise.

The development of a valid apparatus such as this oxyhemograph makes possible the study of varied problems in physiology and medicine, which deal with the degree of oxygenation of the blood.

An Application of the Oxyhemograph in the Prevention and Control of Anoxia. V. G. Behrmann and F. W. Hartman, Henry Ford Hospital.

Although the exact mechanism of narcosis remains controversial, the recent work of Schmidt and Himwich on Pentothal anesthesia suggests that a part of the narcotic mechanism is an histotoxic anoxia. If this theory is accepted, it is obvious that some degree of anoxia is an inevitable complication of anesthesia. Therefore, if anoxia cannot be prevented, its early detection is essential if irreversible tissue damage is to be avoided. Since the oxyhemograph registers a continuous record of arterial blood oxygen, the slightest trend toward anoxic anoxia, i.e., anoxemia, would be apparent. The oxyhemograph, then should prove an invaluable aid in the prevention and control of anoxia in anesthesia.

Studies on Pentothal, Pentothal—O_2, and Pentothal—N_2O — O_2 anesthesia in clinical and experimental subjects are shown which demonstrate the effectiveness of the oxyhemograph in recording an accurate tracing of blood oxygen saturation. The sensitivity of the instrument is such that the first warning of developing anoxemia is recorded much earlier than can be appreciated by clinical observations. These data show that the oxyhemograph is an effective tool for the evaluation of anesthetics, as well as an instrument of practical value in clinical anesthesia. Its scope and application to the study of all conditions which are related to anoxemia and anoxia is discussed.

THE PHYSICIAN AND THE CHILD

(Continued from Page 194)

Conclusion

Slowly but definitely, evidence is accumulating to support the thesis that there are two complementary sides to medical practice—the physical and psychical—which operate in every patient we are called upon to treat. To date, most of this evidence comes from studies on the adult patient. However, it holds equally true for the child, who likewise is an individual subjected to emotional stresses and strains. Recognizing and accepting this fact, no physician can afford to neglect either method of approach to the problems our children present.

Today there is increasing concern on all levels, local, state and national, over our greatest and most baffling medical problem, namely, nervous and mental disorders. The recently passed National Mental Health Act should serve ultimately to help us all. Many states are giving serious attention to it and are setting up programs designed to give us the help needed. Of these, Michigan is among the most progressive in establishing strategically located centers to serve its residents. An increasing number of medical schools are emphasizing the importance of the problem and are providing more adequate instruction in this new field. All of these merit our support.

But most important of all is our daily patient-by-patient contact. As we physicians give due weight to the relative importance of the emotional tensions inherent in each case and help our patients accordingly, we can institute a program of prevention and become active participants in promoting an effective program of mental hygiene.

Traditionally, we have been largely interested in the diseases of children. By shifting our interest to the child himself, we shall begin to assume fuller responsibility for shaping the adult he will become. In this way we will help conserve our country's richest resource, its people.

Immunization

On December 27, 1947, Governor Kim Sigler issued a proclamation which read in part as follows:

"I, Kim Sigler, Governor of the State of Michigan, do hereby designate the month of February, 1948, as Immunization Month in Michigan, and urge all our citizens to co-operate with Michigan's practicing doctors of medicine and official health agencies in their campaign to stamp out certain communicable diseases, to the end that we may have a still healthier State in which to live."

The Michigan State Medical Society and the Michigan Department of Health are co-operating in a voluntary program during the month of February, aimed at controlling, and eventually eradicating smallpox, diphtheria, whooping cough and tetanus. These are the diseases for which the medical profession has proved protective materials.

This program, designed to reach every child in Michigan regardless of economic status, will be carried out in co-operation with local health departments and county or district medical societies.

It is to be hoped that each doctor of medicine in Michigan will lend his whole-hearted support to this program of immunization in response to this splendid proclamation of our Governor.

P. L. Ludwidge

President, Michigan State Medical Association

President's



Page

Editorial

SOCIALIZED MEDICINE, THE THIEF OF CHARACTER

AS ANTICIPATED, President Harry S. Truman, in his State of the Nation message to Congress, January 7, 1948, again urged socialized medicine. He does not call it by that name, and he does not say "compulsory" this time, but he very definitely urged the same old program. He says:

"The greatest gap in our social security structure is the lack of adequate provision for the Nation's health. We are rightly proud of the high standards of medical care we know how to provide in the United States. The fact is, however, that the most of our people cannot afford to pay for the care they need.

"I have often and strongly urged that this condition demands a national health program. The heart of the program must be a national system of payment of medical care based on well tried insurance principles. This great nation cannot afford to allow its citizens to suffer needlessly from the lack of proper medical care.

"Our ultimate aim must be a comprehensive insurance system to protect all our people equally against insecurity and ill health."

Let's have a look!!

"Most of our people cannot afford to pay for the care they need." How about it? The vast majority of the people ARE NOW PAYING for the medical care they need. The only ones who cannot are the indigent, who are cared for. Many of the middle and lower income group find the costs high, and sometimes calamatous. Some do not attempt to pay. But those who have a little initiative and are willing to try can provide for their care by prepayment. The plans are available. The president ignores over eighty million who are now carrying some form of prepayment insurance. This number is over half the population and makes the above quotation inaccurate.

The word "compulsory" is missing from this message but instead it says: "a comprehensive insurance system to protect all of our people equally, against insecurity and ill health." The word compulsory is not needed, but the designation socialized medicine is inescapable.

We are a great nation, but it was not built by sitting back and letting someone else carry the load. Our forefathers, and our fathers were men willing to DO things—not wait and ask for "Security." They worked and made their own security. This generation seems to have lost something highly desirable. They want "protection"; they want guaranteed jobs, hours of work; they want assurance that their health will be protected, even if they are too shiftless, or lack the foresight, to take advantage of the many plans for their own protection.

The greatest thing this nation needs is a reversion to the grim idea of DOING things, of independence, of looking after their own. If our people thought as much of their families as the pioneers did, they would provide for this health service by budgeting—by prepayment. Our fathers provided their wants at whatever cost. Now the prudent man can do with comparative assurance what the social planners would do for him and take away his independence. What we need is GRIT and MORE GRIT.

POLIOMYELITIS AND TONSILLECTOMY

FOR MANY YEARS children's tonsils have been removed during the summertime, opportune because of school vacations and low prevalence of respiratory diseases and infections. It seemed the ideal time. Epidemiologists then advanced their theory that recent tonsillectomies predispose to poliomyelitis infection, and advised that tonsillectomies should not be done especially during the summer months which are the predominant months for spread of poliomyelitis. This idea was taken up by health authorities with advice direct to the general public against operating on the throat during or preceding poliomyelitis prevalence.

We commented on this editorially in September, 1946 (pages 1128 and 1130); also in December, 1946 (page 1635). We questioned the connection, but asked for further information and proof of danger. We asked for facts. In the December, 1946, JOURNAL (page 1656), we published a letter from Dr. Franklin Top of the Detroit Health Department giving reports of a survey which tended to show that a tonsillectomy at any time in the past was a liability as far as poliomyelitis contagion

was concerned. We believed a determination of the relative number of persons who had recently been tonsillectomized would not materially differ from the number of poliomyelitis victims who had been tonsillectomized.

We have made an attempt to make such a study, using the numbers of tonsil operations done in a year as a measure of percentage. In 1946, Michigan Medical Service paid for 14,758 tonsillectomies done on 840,000 persons holding certificates. This is 1.75 per cent, or one and three-quarters for each one hundred persons. In the City of Battle Creek, in its five hospitals, there were 1,218 tonsillectomies during this same year (1946). Estimating 65,000, which is 20,000 over the last census report, this makes 1.87, or one and seven-eights per hundred people. Incidentally, we had only five poliomyelitis cases, and the health department has no record of whether they had tonsils or not.

. The *Archives of Otolaryngology,* of November, 1947 (page 575), has a paper by Daniel S. Cunning, M.D., of New York, in which he reports a study of the relationship of tonsillectomy and poliomyelitis. There were 25,204 cases in the whole nation, and he gives a final summary covering 5,872 cases. Of these patients, ninety-one, or 1.6 per cent, had recent tonsillectomies. Dr. Cunning suggested a study of all tonsillectomies done in a large group of hospitals, with a follow-up to determine how many of these patients developed poliomyelitis.

To recapitulate, Dr. Cunning found that 1.6 per cent of poliomyelitis cases had a history of recent tonsillectomies. Michigan Medical Service finds that the general public was 1.75 per cent tonsillectomized, and the city of Battle Creek, 1.87 per cent, both favorable ratios, actually showing protection by 0.15 to 0.27 per cent. These percentages are so close that we must conclude that tonsillectomy has very little, if any, influence on the prevalence of poliomyelitis. And these figures for poliomyelitis cover 23.3 per cent of all cases in the United States. The figures for the general population of Michigan cover 900,000 persons, and should give a fair average.

Why do we again bring up this problem? Because *it is* a problem. We, as conscientious doctors, wish to give our patients the very best of care and advice. If we are increasing the danger of poliomyelitis infection we would like to know it. However, if we are to change the time of doing tonsillectomies from the most favorable season to one having manifest dangers, such as respiratory infections, or if we are to forego them entirely, and fail to protect these patients from known infections, such as rheumatism of childhood, otitis, et cetera, we must have a sound reason. Dr. Cunning raises these questions, and asks for more research.

This editorial had just been completed when the following came to our attention, forwarded by a friend who is interested in the subject because of his specialty, pediatrics:

"TONSILS LINK TO POLIO DOUBTED. San Francisco, Dec. 22-'47.—Tonsil operations apparently do not increase the danger of contracting infantile paralysis, a University of California medical school survey indicated today.

"Researchers studied 429 cases brought to two hospitals here between 1941 and 1945. These cases came from thirty-four counties in which there had been 57,796 operations for the removal of tonsils or adenoids and 2,057 cases of poliomyelitis in the four-year period.

"The number of tonsillectomized persons who contracted infantile paralysis was not greatly out of proportion to the number among the general population, the survey showed."

IMMUNIZATION OF CHILDREN

THE MICHIGAN STATE Medical Society, through its committees, especially the Committee on Child Welfare, has long advocated the immunization of children in so far as possible. Childhood, and especially infancy, is the ideal time, and we are now again advocating that our members protect the children at every reasonable opportunity.

Over a year ago the American Academy of Pediatrics, Michigan Branch, conducted a survey covering the whole state, to learn the extent of immunization and to increase it. This survey was completed and established another "Michigan First." Immunization of infants and children has increased in private practice.

Our Society is again expressing its advocacy of immunization, and is making the subject one of the main topics of the Second Annual Postgraduate Clinical Institute to be held in Detroit, March 10, 11, 12, 1948. In our Secretary's Letters and in official communications, the Council calls upon our members to do a complete job in immunization of the young and we proudly boast of Michigan's prominence in this new endeavor.

The Governor has issued a call for a special period of immunization, and we shall gladly cooperate. We believe this work can best be done in the doctor's private offices.

EARLY IMMUNIZATION OF CHILDREN

SOME OF THE advocates of state control of medical practice are constantly ringing the changes on the statement that "the practicing physician is not interested in preventive medicine." We believe that such an allegation is untrue. We further believe that it has been proven untrue through the ages during which Medicine has seized avidly anything that gave reasonable hope of preventing disease. There may be, however, a marked difference betwen the official attitude of organized medicine and the individual attitudes of medical practitioners. Of greater importance is the fact that while a doctor may support and advocate a valuable preventive procedure, he frequently finds practical obstacles in the way of putting the procedure into practice with his own patients.

A case in point is the early immunization of children. Everyone agrees that all infants should be immunized against whooping cough, diphtheria, smallpox, and possibly should have received tetanus toxoid during the first year of life. In the case of whooping cough, many pediatricians now believe that injections should be started at an age of three months or even earlier. Yet the fact remains that a major proportion of the children entering school at the age of five years have not had anything approaching such a program. This has resulted in a considerable demand that the public health agencies take over the responsibility for immunization. This demand is based on the following allegations: (1) Private practitioners have not covered a sufficient segment of the population. (2) Since general immunization programs protect the public, as well as the individual who is immunized, such service should be free to the individual.

There are obvious dangers to the public in using a public health organization to immunize infants. The assembly of babies in large numbers in clinics is undesirable from a public health standpoint. Since there may be certain infants whose physical state is such that immunization should be deferred, it is questionable whether a public health nurse is the proper person to make the necessary determinations as to the advisability of giving this or that infant this or that injection. From the standpoint of the physicians, an injection is treatment and as such is a procedure which should be performed by a physician in his private office.

It is believed that most health officers would subscribe to the above statements. We have rarely found a public health administrator who is eager to cope with the problems incident to the mass inoculation of infants. The great majority would prefer to have it carried on in the office of the private physician. It is reasonable to suppose, however, that continued failure of organized medicine to cope with this matter may force action in the interest of public health. It is incumbent on every physician who treats babies to urge the parents to permit proper preventive measures. Experience has shown that when the procedure is properly explained to them, mothers and fathers rarely refuse. It is further the duty of the physician to see that fees for immunization are not so high as to offer a serious deterrent.

If private physicians can solve this problem they will render a real public service. If, however, the majority of children continue to reach school age unprotected against the contagious diseases for which protection is available, Medicine can have no proper objection to public health authorities taking matters into their own hands.

H.F.B.



ON THE RUN . . .

In women, pulmonary tuberculosis rises to a peak at the age of twenty-three, while in males it has a greater and rising incidence from thirty-five on.

. . .

If acute reaction with hemoglobinuria follows blood transfusion, repeated transfusions of compatible blood are immediately indicated to prevent shock and promote renal blood flow.

. . .

Para-aminosalicyclic acid has demonstrated its effectiveness in controlling tuberculosis in guinea pigs and is now being tried in humans.

Selected by WILLIAM S. REVENO, M.D.

Chairman Hull on Medical Public Relations



Upon L. W. Hull, M.D., Detroit, has been placed the responsibility of chairmanning the Public Relations Committee of the Michigan State Medical Society for the year 1948. Dr. Hull is highly qualified for his new appointment by long and effective service in organized medicine and medical public relations. His statement appears below.
—EDITOR.

"It must be evident to all of us as medical men and women, whether it is approved of by the profession as a whole or by its members as individuals, that American medicine must get into the political game and pitch if it is to survive as an independent body of self-respecting individuals in this country of ours. Only a cursory look through the news of today and yesterday shows that powerful forces, in their own aggrandizement, add to their power and control over the lives of the citizens of these United States. What can the individual physician and his medical societies do to preserve the independence of his chosen profession?

"We hear a great deal about public relations these days. Good public relations for the medical profession simply mean the creation of good will on the part of our patients, the American people, toward our efforts to see that they get the best possible medical care and that they understand how they can be assured of a continuation of that same kind of care in the future. This requires that the individual practitioner keeps up to date in his profession and gives the best service of which he is capable. It is also necessary that the physician know the moves being made on the chess board of politics by those seeking to control the practice of medicine and explain to his patients how the moves will affect them and the medical care they have the right to expect. He should take time off from his practice to initiate and lead in community work for the betterment of life and health in his community.

"The Michigan State Medical Society in the past six years has built up a program of public relations of which the profession of Michigan has good reason to be proud. The program is ably managed by Mr. Hugh W. Brenneman under whose direction successful programs in Medical news and information in newspapers, on the radio and by public addresses have been activated. Mr. Brenneman has lent his assistance to lay groups to further their plans for better public health. This year the Michigan State Medical Society is enlarging its public relations programs by entering the cinema field. By this means it is thought that a larger number of people may be reached than by any other method and that medical care and facts may be presented in an understandable and pleasing way. Michigan has received national recognition for the excellence of its public relations program. It is to be hoped that soon programs of the various states and that of the American Medical Association will be integrated to a degree not present at this time. By pooling its resources the medical profession can put on a program of public relations, locally and nationally, in the news, over the air and on the silver screen which would command the attention and respect of our fellow citizens. The American people must be shown that our profession is in dead earnest in trying to preserve for them the best of medical care.

"In a world in which the trend toward socialism is making rapid strides the private practice of medicine has an answer to state medicine in its voluntary prepayment medical care plans. Good public relations require the co-operation of all practitioners of medicine, who, individually and collectively, must educate the public as to the value of the present voluntary system of medical practice. Public relations should provide good publicity, not bad publicity, news and information, not propaganda."

ROCKY MOUNTAIN SPOTTED FEVER APPEARS IN MICHIGAN

(Continued from Page 187)

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MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

Detroit, March 10-11-12

The second annual Michigan Postgraduate Clinical Institute, featuring an all-Michigan program (Pages 142 and 143) will be held at the Book-Cadillac Hotel, Detroit, Wednesday, Thursday, Friday, March 10-11-12, 1948.

The Committee on Arrangements and Program is composed of H. H. Cummings, M.D., Chairman, Ann Arbor; G. C. Penberthy, M.D., Detroit; L. F. Foster, M.D., Bay City; P. L. Ledwidge, M.D., Menominee, H. M. Bishop, M.D., Saginaw, C. A. Scheurer, M.D., Pigeon, Merrill Wells, M.D., Grand Rapids—representing out-state practitioners and the Upper Peninsula; and, D. H. Kaump, M.D., Detroit, H. A. Kemp, M.D., Detroit, E. A. Osius, M.D., Detroit, Arch Walls, M.D., Detroit—representing Wayne County Medical Society and Wayne University College of Medicine.

GENERAL OUTLINE

	Wednesday March 10, 1948	Thursday March 11, 1948	Friday March 12, 1948
8:30-9:00 a.m.	Registration. Exhibits Open	Registration. Exhibits Open	Registration. Exhibits Open
9:00-12:00 M	Six practical talks	Six practical talks	Six practical talks
12:00 M-2:00 p.m.	Luncheon and speaker	Luncheon and speaker	Luncheon and speaker
2:00-4:20 p.m.	Four instructive talks	Four instructive talks	2:00-2:40 p.m., Clinical Pathological Conference (Medical Case)
4:20-5:00 p.m.	Clinical X-Ray Conference	Clinical Pathological Conference (Surgical Case)	2:40-5:00 p.m., Five interesting talks
6:30 p.m.	Dinner Hour	Dinner Hour	End of Institute
8:00-10:00 p.m.	Question Box (5 participants)	Panel Discussion (6 discussants)	
10:30 p.m.	Smoker and Entertainment		List of Exhibitors on Page 212

All members of the Michigan State Medical Society are invited and urged to attend this important Institute. For hotel accommodations write E. C. Texter, M.D., Chairman of Committee on Hotels, 1005 Stroh Building, Detroit 26, Michigan. Railroad accommodations, such as on the Streamliner to Detroit, should be secured at an early date.

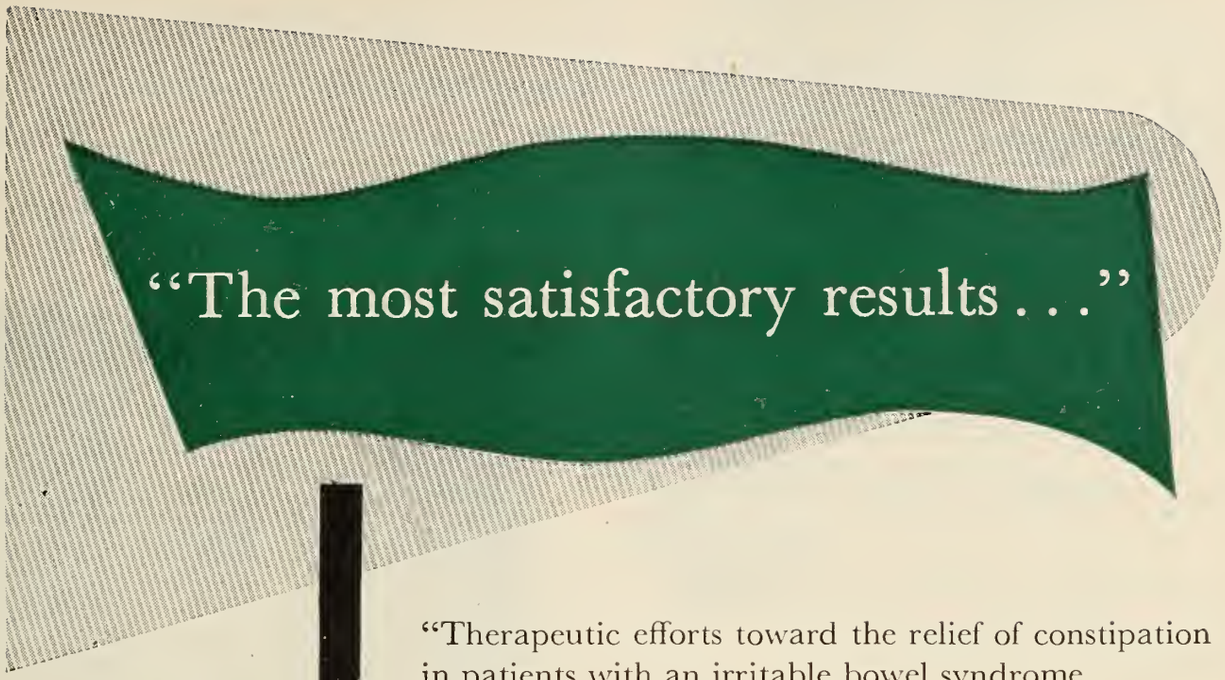
The accompanying general outline is the summary of the three-day postgraduate Institute—an opportunity to help you keep abreast of your swiftly moving science.











IRRITABLE BOWEL SYNDROME

"Therapeutic efforts toward the relief of constipation in patients with an irritable bowel syndrome must be continued over prolonged periods of time. Cathartics which exert their action by direct irrigation of the intestinal mucosa have no place in long-term bowel management. . . . The most satisfactory results were obtained with a hydrophilic mucilloid [Metamucil] prepared from psyllium seed. . . ."*

METAMUCIL

When prolonged treatment is indicated, Metamucil—the "smoothage" management of constipation—fits well into the program.

Smooth, gentle, normal evacuation—the desired action in the irritable bowel syndrome—is afforded by the use of Metamucil.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

*Dolkart, R. E.; Dentler, M., and Barrow, L. L.: The Effect of Various Types of Therapy in the Management of the Irritable Bowel Syndrome, Illinois M. J. *90*:287 (Nov.) 1946.

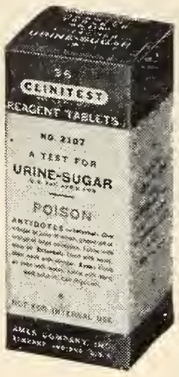
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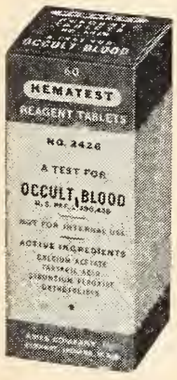
TABLET NO-HEATING METHOD



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Drop one Clinitest Tablet in indicated amount of diluted urine—watch for reaction—compare with color scale.

OCCULT BLOOD



HEMATEST

TABLET METHOD

SIMPLE TECHNIC

Place one drop of specimen solution or suspension on filter paper. Set Hematest Tablet in center of moist area and allow 2 drops water to trickle down from top of tablet to paper. Color reaction on paper denotes presence of blood.

Full information on request.

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In Memoriam

Fred Taylor Andrews, M.D.—Bay City, Michigan. Born April 9, 1887, at Adrian, Michigan. Received education at Adrian High School, Adrian College, Detroit College of Medicine and Surgery. Interned in Chil-



FRED TAYLOR ANDREWS, M.D.

dren's Free Hospital and Woman's Hospital, Detroit. Former Councilor of Michigan State Medical Society for Fourth District. In 1939 took a postgraduate course in Public Health at University of Michigan. In First World War served as Lieutenant in the Navy, 1917-1918. Former Bay County Health Director. At the time of death, surgeon and medical advisor for the Greyhound Lines, Bay City Electric Steel Casting Company and National Electric Welding Machines Company. Senior surgeon at Mercy and General Hospitals. President of the Bay County Chapter of Michigan Society for Crippled Children. Member of American Medical Association, Michigan State Medical Society, Bay County Medical Society, American Association of Industrial Physicians and Surgeons, Association of Military Surgeons. Also member of the Elks, Rotary Club, and Phi Chi Fraternity, Masonic Order, and the American Legion. Wrote articles entitled "Method of Reduction of Carpal Bones of the Wrist" and "Report on Solitary Cysts of the Spleen." Doctor Andrews passed away Sunday, December 21, 1947, at Bay City, at the age of sixty.

* * *

Henry M. Abrams, M.D.—Detroit, Michigan. Born at Detroit in 1900. Obtained medical education and training at University of Michigan, graduating with class of 1928. Member of Wayne County Medical Society and for twelve years member of the Michigan

Say you saw it in the Journal of the Michigan State Medical Society

State Medical Society. Survived by wife, Evelyn, daughter, Donna, and brother, Lewis. Dr. Abrams passed away September 5, 1947, in Detroit at the age of forty-seven.

* * *

Albert Lissell Callery, M.D.—Port Huron, Michigan. Born in Hastings County, Ontario, Canada, in 1885. In June of 1897 was graduated from University of Toronto with M.D. and C.M. degrees. Was Assistant Director of the Port Huron-St. Clair County Department of Health. Member and long time Secretary of the St. Clair County Medical Society. Elected to Life Membership in the Michigan State Medical Society, September, 1945. He also was a charter member of the MSMS Fifty-year Club. Doctor Callery died December 3, 1947, at Port Huron, Michigan, at the age of eighty-two.

* * *

William R. Chittick, M.D.—Spring Valley, California. Born in Oshawa, Ontario, Canada, in 1857. Received education at Michigan College of Medicine and the Long Island College Hospital, New York. Was director of the Detroit Newsboys Association for 26 years. Associated with St. Mary's and Harper Hospitals and was president of the Detroit Academy of Medicine, 1895-6. He was a member of the Wayne County Medical Society and in September of 1937 was elected to Emeritus Membership in the Michigan State Medical Society, and also was a Charter Member of the MSMS Fifty-Year Club. Dr. Chittick retired from practice in 1927 and passed away January 2, 1948, at Spring Valley, California, at the age of ninety.

* * *

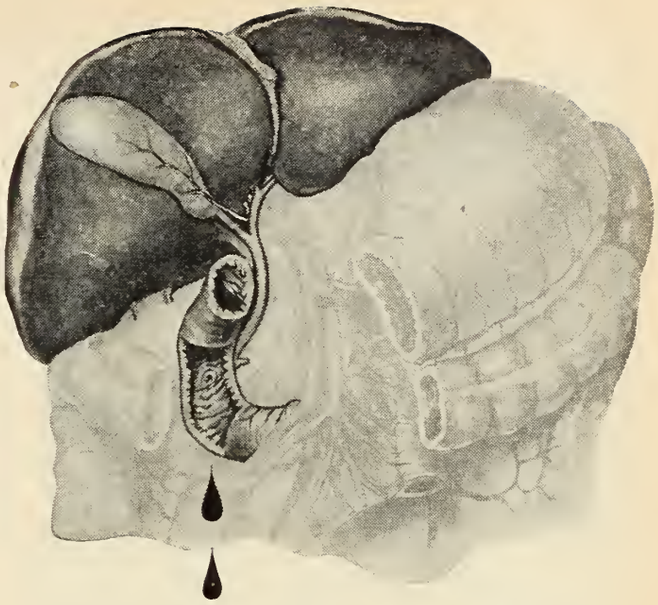
James Harry Cox, M.D.—Detroit, Michigan. Born in Calumet in 1872. Received medical education at the University of Michigan Medical School, Class of 1902. Served in the Spanish-American War. Formerly a member of Wayne County Medical Society and the Michigan State Medical Society. Dr. Cox passed away November 25, 1947, in Detroit, at the age of seventy-five.

* * *

Robert Emmet Flood, M.D.—Gladwin and Northport, Michigan. Born in 1870. Received education at University of Louisville Medical College, Class of 1897. Was village president for several terms. Formerly member of Wayne County Medical Society and the Michigan State Medical Society. Dr. Flood expired December 7, 1947, in Gladwin, Michigan, at the age of seventy-seven.

* * *

Ray Thomas Fuller, M.D.—Kalamazoo, Michigan. Born in Montcalm County, October 15, 1875. Received education at Carson City High School. Entered University of Michigan Medical Department in 1895. Dropped out of medical school to teach in rural schools but completed medical education at the Saginaw Valley Medical College in 1903. President of the Kalamazoo Council of Churches and Christian Education, the Burr Oak Lodge, I.O.O.F., Fidelity Masonic Lodge. Also a member of the Kalamazoo Academy of Medicine, and the American Medical Association. In September of 1946 was elected to Life Membership in the Michigan



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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State Medical Society. Doctor Fuller died January 7, 1948, at the age of seventy-two, in Kalamazoo, Michigan.

* * *

Sidney B. Goff, M.D.—Eaton Rapids, Michigan. Born 1898. Served in World War II as Captain in the Army Medical Corps. Member of the Eaton County Medical Society and the Michigan State Medical Society. Dr. Goff died December 26, 1947, in Eaton Rapids, at the age of forty-nine.

* * *

T. W. K. Hume, M.D.—Pontiac, Michigan. Born at Toronto, Ontario, Canada, in 1901. Received medical education at the Toronto School of Medicine. Member of the Oakland County Medical Society and the Michigan State Medical Society. Dr. Hume is survived by wife; Professor James G. Hume, his father, of Toronto; one sister and three brothers. Dr. Hume expired January 1, 1948, in Pontiac, Michigan, at the age of forty-six.

* * *

William H. Marshall, M.D.—Flint, Michigan. Born March 24, 1874, at Brampton, Ontario, Canada. Obtained education at Trinity Medical College, Toronto, Class of 1901. Took postgraduate work at University of Edinburgh and University College of London, England. Served with the British Royal Army Medical Corps in 1916-1917; and with the United States Medical Reserve Corps as Major in 1918. President of Northern-Tri-State Medical Association, 1936; President of the Genesee County Medical Society in 1926. Also served as President of the Michigan Trudeau Society; and honorary member of the Flint Academy of Surgery and the Flint Academy of Medicine. Was Chief of the Department of Medicine, Hurley Hospital, for 15 years. Fellow of the American College of Physicians. Member of the Board of Registration in Medicine six years (Michigan). Past president Wranglers Club, Flint. Member of Michigan Academy of Science, Arts and Letters, of Charles Durand Lodge, F. & A. M., and Royal Arch Masons. Doctor Marshall also was a member of the American Medical Association, and in September of 1947 was elected to Life Membership in the Michigan State Medical Society, which organization he served as president in 1927. He died at Flint, Michigan, at the age of seventy-three years, January 8, 1948.

* * *

Samuel H. Rutledge, M.D.—Rogers City, Michigan. Born in Ontario, Canada, November 25, 1878. Received medical education at Queen's College, Kingston, Ontario, Class of 1904. Interned at the Post Graduate Hospital, Chicago. Former member of the Alpena County Medical Society and the Michigan State Medical Society. Main interest was surgery but he was very successful as a general practitioner. Dr. Rutledge expired December 29, 1947, at Rogers City, Michigan, at the age of sixty-nine.

* * *

Jeanne Cady Solis, M.D.—Ann Arbor, Michigan. Born in Mooretown, Ontario, Canada, February 13, 1867. Graduate of the Medical School of the University of Michigan, Class of 1892. Charter member of Alpha Epsilon Iota (Women's Medical Sorority). Member of the Washtenaw County Medical Society, and was elected

to Emeritus Membership in the Michigan State Medical Society in September of 1942. Also Charter Member of the MSMS Fifty-Year Club. Dr. Solis retired from active practice in 1944 and died December 18, 1947, at Ann Arbor, Michigan, at the age of eighty.

* * *

Edgemont D. Welsh, M.D.—Grand Rapids, Michigan. Born in St. Louis, Missouri, 1884. Obtained medical education at the Michigan College of Medicine and Surgery, Detroit, graduating in the Class of 1904. Former member of the Kent County Medical Society and the Michigan State Medical Society. Dr. Welsh passed away December 5, 1947, in Grand Rapids, Michigan, at the age of sixty-three.

* * *

We Are Sorry

Our humble apology to Wayne A. Geib, M.D., Rapid City, South Dakota, for printing his obituary in THE JOURNAL MSMS, Page 96, of the January, 1948, issue.

Word has been received from L. O. Geib, M.D., Detroit, Michigan, that his son Wayne is very much alive and is the pathologist to St. Johns Hospital and Black Hills Memorial Hospital of Rapid City, South Dakota, St. Joseph's Hospital at Deadwood and Veteran's Hospital at Sturgis, South Dakota.

We regret this error caused through the receipt of inaccurate information.

It might be proper at this time to state that THE JOURNAL MSMS receives meager information concerning the death of former members and if arrangements could be made to have exact information concerning their departure from this old globe forwarded to THE JOURNAL MSMS, longer articles could be printed. Maybe this information should come from the County Medical Society. We at the JOURNAL office feel that every deceased member should be given generous space in the "In Memoriam" column so that colleagues may be informed of their loss. Co-operation of members and county secretaries in this matter is solicited.

Woman's Auxiliary

The Woman's Auxiliary to the Michigan State Medical Society has adopted as one of its projects the sale of Easter Seals for the Michigan Society for Crippled Children and Disabled Adults, Inc.

Mrs. T. Grover Amos, president, has appointed the following committee to assist with the Easter sale of 1948: Mrs. C. T. Mehas, Pontiac; Mrs. Walter S. Stinson, Bay City; Mrs. Leonard Folkers, Lansing.

Mrs. Amos also appointed the following committee to work on the Red Cross Blood Bank project: Mrs. R. S. Breakey, Lansing; Mrs. L. Paul Sonda, Detroit; Mrs. L. O. Shantz, Flint.

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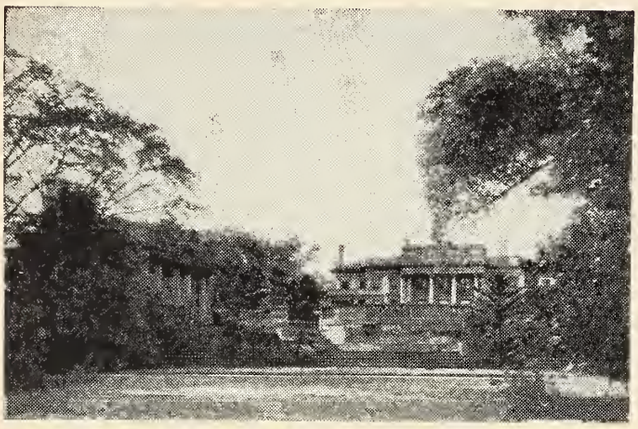
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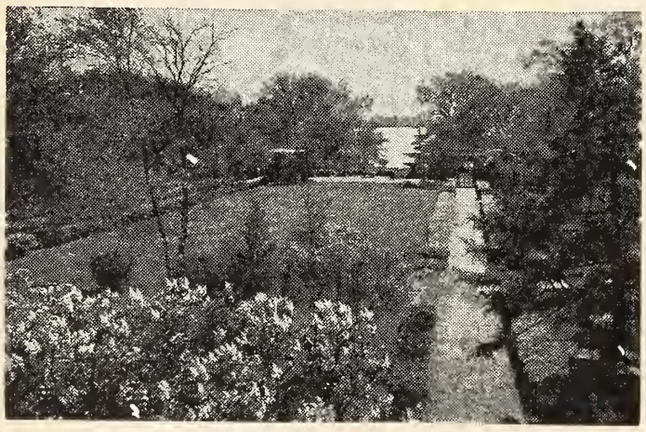
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Becton Dickinson & Co., Rutherford, N. J., Booth No. 34
Bilhuber-Knoll Corporation, Orange, N. J., Booth No. 18
The Borden Company, New York, Booth No. 4
Camel Cigarettes, New York, Booths No. 28 and 29
S. H. Camp & Company, Jackson, Mich., Booth No. 56
Ciba Pharmaceutical Products, Inc., Summit, N. J., Booth No. 38
Cottrell-Clarke, Inc., Detroit, Mich., Booth No. 12
Davis & Geck, Inc., Brooklyn, N. Y., Booth No. 57 & Cinema Room
Detroit X-Ray Sales Company, Detroit, Mich., Booths Nos. 54 and 55
Doho Chemical Corporation, New York, Booth No. 24
Electro Chemical Equipment Co., Detroit, Mich., Booth No. 25
Farnsworth Laboratories, Chicago, Ill., Booth No. 21
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G. D. Searle & Company, Chicago, Ill., Booth No. 44
Sharp & Dohme, Inc., Philadelphia, Pa., Booth No. 48
Smith, Kline & French Labs., Philadelphia, Pa., Booth No. 16
VanPelt & Brown, Inc., Richmond, Va., Booth No. 22
White Laboratories, Newark, N. J., Booth No. 23
Winthrop-Stearns, Inc., New York, Booth No. 51

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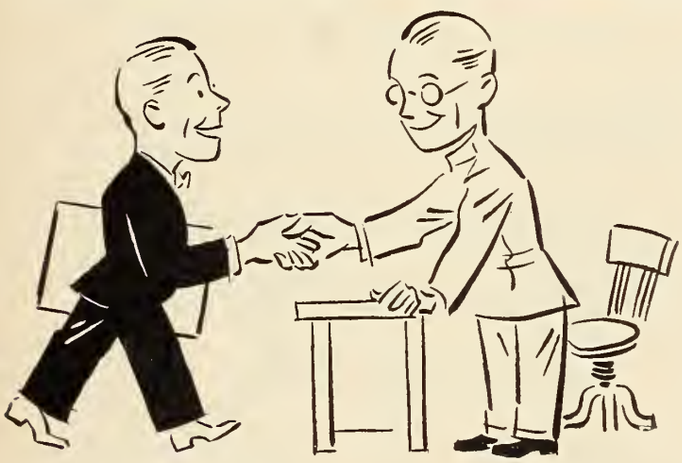
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What's What

Be sure to renew your Federal and State Narcotic licenses on or before July 1, 1948.

* * *

A. C. Furstenberg, M.D., Ann Arbor, is the author of an original article, "Diseases of the Salivary Glands" which appeared in JAMA, January 3, 1948.

* * *

The Oakland County Social Welfare Board adopted the Uniform Fee Schedule for Governmental Agencies as of December 22, 1947.

* * *

John S. Lambie, M.D., Birmingham, has been appointed as MSMS representative to the Health Committee of the Michigan Congress of Parents and Teachers.

* * *

Earl A. Peterman, M.D., of Detroit is the author of a paper on "Glucuronic Acid Deficiency in the Rheumatic Diseases" published in the *Journal-Lancet,* December, 1947.

* * *

Archives of Surgery, November, 1947, contained two papers by Michigan doctors: "Medullary Tractomy for Relief of Intractable Pain in Upper Levels" by A. C. Crawford, M.D., Detroit; and "Experiences With the Blalock Operation for Tetralogy of Fallot," by F. D. Dodrill, M.D., Detroit.

The University of Texas, Medical Branch, Galveston, announces a postgraduate course in physical medicine and rehabilitation to be held March 1-5, 1948. For program and full information write W. A. Selle, Director, University of Texas, Medical Branch.

* * *

"It is the overwhelming consensus of expert opinion that the Administration will undertake a relentless drive for the enactment of compulsory sickness insurance legislation this year—1948 is the 'Year of Decision.' "—National Physicians Committee, December 11, 1947.

* * *

"It is as difficult to be neutral about compulsory sickness insurance as to be neutral about the commission of murder."

"In other countries legislation for national social insurance has always meant subjugation of the individual to the Government."—*American Medicine and the Political Scene,* December 26, 1947.

* * *

John Martin Weller, M.D., Ann Arbor, has been awarded the first Alfred Stengel Research Fellowship by the American College of Physicians. This will enable Dr. Weller to undertake studies concerning the ionic pat-

(Continued on Page 216)

HOSPITALS IN THE STATE OF MICHIGAN APPROVED FOR ROTATING INTERNSHIP TRAINING

Michigan State Board of Registration in Medicine
Revised to October, 1947.

Name of Hospital	Location	Capacity	Total Patients Admitted	Internships	Stipend per Month	Service Commences
St. Joseph's Mercy Hospital	Ann Arbor	313	6,954	6	$100.00	July
University Hospital	Ann Arbor	934	14,471	27	20.00	July
Leila Y. Post Montgomery Hospital	Battle Creek	200	6,749	2	100.00	July
Mercy Hospital	Bay City	160	5,455	3	100.00	July
Charles Godwin Jennings Hospital	Detroit	108	2,658	4	125.00	July
City of Detroit Receiving Hospital	Detroit	633	16,816	40	103.00	July
Evangelical Deaconess Hospital	Detroit	225	6,906	6	150.00	July
Grace Hospital	Detroit	513	15,194	36	50.00	July
Harper Hospital	Detroit	685	19,950	36	28.00 (b)	Varies
Henry Ford Hospital	Detroit	634	16,430	30	170.00 (a)	July
Mt. Carmel Mercy Hospital	Detroit	575	16,227	12	100.00	July
Providence Hospital	Detroit	444	12,873	20	125.00	July
St. Joseph's Mercy Hospital	Detroit	246	7,202	4	100.00	July
St. Mary's Hospital	Detroit	350	9,795	12	75.00	July
United States Marine Hospital	Detroit	293	3,892	6	162.81	July
Woman's Hospital	Detroit	352	8,138	6	80.00	July
Wayne County Gen. Hosp. & Infirm.	Eloise	6,368	5,205	24	167.50	July
Hurley Hospital	Flint	484	13,899	16	50.00	July
St. Joseph Hospital	Flint	275	7,105	4	....	July
Blodgett Memorial Hospital	Grand Rapids	210	5,039	6	75.00	Quarterly
Butterworth Hospital	Grand Rapids	286	9,081	8	50.00	July
St. Mary's Hospital	Grand Rapids	321	8,255	7	100.00	Varies
Highland Park General Hospital	Highland Park	300	8,085	8	100.00	July
W. A. Foote Memorial Hospital	Jackson	185	5,632	2	100.00	July
Mercy Hospital	Jackson	150	5,045	3	150.00	August
Borgess Hospital	Kalamazoo	295	6,184	4	100.00	July
Bronson Methodist Hospital	Kalamazoo	170	5,072	6	100.00	July
Edward W. Sparrow Hospital	Lansing	253	7,103	7	230.00	July
St. Lawrence Hospital	Lansing	270	6,712	8	....	July
Hackley Hospital	Muskegon	174	5,177	4	....	July
Pontiac General Hospital	Pontiac	225	7,058	3	165.00	Varies
Saginaw General Hospital	Saginaw	250	7,041	3	50.00	July
St. Mary's Hospital	Saginaw	204	5,791	2	....	July

(a) In lieu of maintenance.
(b) Bonus in addition to salary.

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(Continued from Page 214)

terns of the intracellular fluids and their influence on enzymatic reactions; of acid-base balance in tissues other than skeletal muscle tissues.

Congratulations, Dr. Weller!

* * *

The Detroit Medical Assistants Society held its annual meeting in December and elected Mrs. Ruth Ceaser, 1025 David Whitney Bldg., Detroit, as president, and Mrs. Sara Coffman, 901 David Whitney Bldg., Detroit, as chairman of the Detroit Convention Committee in charge of arrangements for the meeting scheduled for September 24, 1948.

* * *

J. Duane Miller, M.D., Grand Rapids, Councilor of the Fifth District, MSMS, was guest speaker on the occasion of the annual convention of the Michigan Association for Health, Physical Education, and Recreation, in Grand Rapids on February 20. Dr. Miller's subject was "The Relationship of Health and Physical Education to Medicine."

* * *

Civilian doctors may now become commissioned officers in the regular Navy, with no age limit (formerly thirty-two years of age), provided they meet professional and physical qualifications, according to a recent communication from C. A. Swanson, Rear Admiral, Surgeon General, U. S. Navy. Doctors in civilian practice may enter the Navy and be commissioned with the rank up to and including Captain. For information write the Bureau of Navy Personnel via Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

* * *

The United States News compares purchasing power in 1939 before high income tax and after, with the same salaries now related to increased taxes and living costs, as follows:

$ 10,000	then yielded	$ 9,657;	now	$ 5,055
12,000	then yielded	11,478;	now	5,896
15,000	then yielded	14,169;	now	7,057
25,000	then yielded	22,673;	now	10,235
100,000	then yielded	68,003;	now	23,416

* * *

The Rocky Mountain Medical Journal for October carried an article congratulating the Colorado State Medical Society on its Seventy-Seventh Annual Session. One of the outstanding features of the session was the fact that more than 70 per cent of its members attended. *The Journal* says, "Perhaps a compact state like Rhode Island or Connecticut or Delaware occasionally registers 70 per cent of its membership at an annual session, but any western state has a right to be proud of such a record."

* * *

The MSMS Cancer Control Committee co-operated with the University of Michigan School of Public Health and the Michigan Department of Health in holding an In-service Training Course on Cancer Services, at the School of Public Health, Ann Arbor, on January 26-

Say you saw it in the Journal of the Michigan State Medical Society

27-28. The program was designed primarily for full-time health officers from the cities and counties of Michigan as well as the supervising nurses from these organizations.

* * *

The American Congress of Physical Medicine will hold its midwestern sectional meeting and seminar at Veterans Administration Hospital, Hines, Illinois, February 26-27, 1948. A seminar on spinal cord injuries will feature this meeting, to be addressed by physicians associated with Northwestern University Medical School, the University of Illinois College of Medicine, and the V. A. Hines Hospital. For program write Louis B. Newman, M.D., Chief, Physical Medicine Rehabilitation Service, V. A. Hospital, Hines, Illinois.

* * *

Government now costs Americans more than $51 billion per year—virtually 25 per cent of all the goods and services produced. In the fiscal year 1947, taxpayers paid $39,600,000,000 for Federal government. They paid $5,900,000,000 for state government. They paid $5,600,000,000 for local government. Every citizen feels the impact of this high-cost government. He feels it in runaway prices, in a tax burden which shrinks income, and in inability to put aside funds for a rainy day. —*Michigan Survey,* January 12, 1948.

* * *

Joe A. Clark, Executive Secretary of the Public Relations Committee, State Medical Association of Texas, Fort Worth, was a guest at the Annual County Secretaries-Public Relations Conference of the Michigan State Medical Society held in Detroit, on January 25. In sending him from Texas to Michigan, Secretary Harold M. Williams, M.D., of the State Association wrote: "It appears from the announcement in JAMA that the program of your County Secretaries-Public Relations Conference which you have planned will be of value to us in our Public Relations activities."

* * *

Don't Be Fooled.—The following note from Bulletin No. 14 of the Washington office of the Council on Medical Service sounds nice, but may be deceiving:

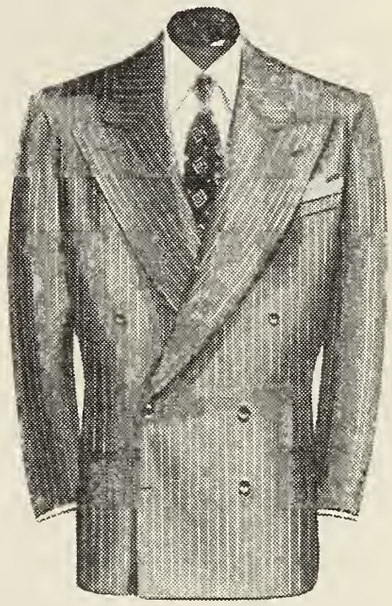
"You are all aware of the fact that *Senator Smith* addressed a communication to the governors of the States early in the summer, asking them several specific questions as to their attitude on S. 545 and S. 1320. It is said that the governors, in their responses, were almost unanimously opposed to Federal interference in health matters in their respective states. They stated that they could best take care of their medical problems themselves."

* * *

Anti-Rh Serum.—The development by Philip Levine, M.D., of a highly accurate diagnostic anti-Rh serum derived from human blood for determining whether an individual has Rh negative or Rh-positive blood has been announced. It is now available for use in hospital and clinical laboratories to prevent intra-group transfusion accidents, and for the selection of Rh-negative blood for the affected infants of Rh-negative mothers.

Dr. Levine did pioneer work in the discovery of the cause of erythroblastosis fetalis, and has for three years

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been director of biological division of the Ortho Research Foundation. This serum now being produced under government license is one of the first to be approved by the National Institute of Health of the U. S. Public Health Service.

* * *

The Association for the Study of Internal Secretions announces a course of lectures and demonstrations in Clinical Endocrinology to be held at the Biltmore Hotel, Los Angeles, February 23 to 28, 1948. This course will be a practical one of value to general practitioners and specialists alike. Among the faculty for the course is Warren O. Nelson, M.D., of Wayne University College of Medicine, Detroit. For program and further information write E. Kost Shelton, M.D., Chairman of the Postgraduate Committee, 921 Westwood Boulevard, Los Angeles 24, California.

* * *

Postgraduate Course in Diseases of the Chest.—The American College of Chest Physicians, Pennsylvania Chapter, and the Laennec Society of Philadelphia are sponsoring a postgraduate course in diseases of the chest to be held during the week of March 15-20, 1948, at the Warwick Hotel, Philadelphia, Pennsylvania.

The emphasis in this course will be placed on the newer developments in all aspects of diagnosis and treatment of diseases of the chest.

The course will be limited to 30 physicians. Tuition fee is $50.00 for members, and $90.00 for nonmembers.

Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

* * *

Chicago Doctors Keep Posted.—The Chicago Medical Society has inaugurated a weekly mimeographed publication entitled "This Week in Chicago Medicine." It was designed to keep the Chicago medical profession posted on "what's going on." The first issue, prepared by Misses Jean McArthur and Ellen Carpenter, lists meetings of the specialty groups, all the medical libraries in the city, the medical schools, a directory of Cook county hospitals, and a schedule of meetings, clinics and conferences planned at Chicago hospitals during the week. Copies may be obtained from the Chicago Medical Society, 30 North Michigan Ave., Chicago 2.

* * *

The Council of the Wayne County Medical Society has recently approved the following recommendations relative to the size of signs for doctors' offices:

"That a sign may be not more than four feet long and two feet wide, with letters not to exceed three inches in height, and that a sign may include the doctor's name, office hours, and state specialty if practice is limited, for example: "Practice limited to Eye, Ear, Nose and that no border may be used on a sign, that only one color may be used for the lettering, and that it be recommended that 'M.D.' be used instead of the title, 'Dr.' "—*Detroit Medical News,* November 17, 1947.

Say you saw it in the Journal of the Michigan State Medical Society

"Is Medical Care Expensive?" . . . Frank D. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the AMA has just published a valuable study on this question. The survey brings out that, although the percentage of average income expended on medical care is declining, the proportion expended for alcoholic beverages, recreation, jewelry, and cosmetics has increased. In fact, in 1946, consumers spent considerably more for both alcoholic beverages and recreation than for medical care.

MSMS members may obtain this study free of charge from the Bureau of Medical Economic Research, AMA, 535 N. Dearborn, Chicago 10, Illinois.

* * *

Michigan Pathological Society.—An annual meeting of the Michigan Pathological Society was held at the University Hospital, Ann Arbor, on Saturday, December 13, 1947, with Dr. Carl V. Weller as host. The scientific meeting included a presentation of problems in pathological diagnosis. The following officers were elected for 1948:

President: A. A. Humphrey, M.D., Battle Creek; President-Elect, D. H. Kaump, M.D., Detroit; Secretary-Treasurer, W. A. Stryker, M.D., Wyandotte; Councilor, S. E. Gould, M.D., Eloise.

The next meeting of the Society will be held in Detroit on February 14, 1948.

* * *

The Harness Committee, continuing its work during the summer, requested certain officials of the Department of Agriculture, located in the Central states, to state their reason for the issuance of certain communications they directed to farm groups earlier this year, calling attention to the reduction Congress was proposing to make in the Department of Agriculture's budget. The Committee wanted to know whether it was the intention of the writers of these communications to stimulate the farmers to file with their Congressmen opposition to the reduction. The contention of the Committee was that the writers of the communications, being at the time employes of the Department of Agriculture, could be said to be lobbying in its interest. The situation is similar to others that the Committee investigated, where Government employes advocated the enactment of health insurance legislation.

* * *

Appointments to State Commissions—

H. H. Cummings, M.D., Ann Arbor, and *E. J. O'Brien, M.D.,* Detroit, were reappointed by Governor Sigler to the State Tuberculosis Sanatorium Commission for terms ending October 9, 1950.

A. D. Allen, M.D., Bay City, and *John R. Rodger, M.D.,* of Bellaire, were appointed as members of the Michigan Advisory Hospital Council (under the 1947 Hospital Survey and Construction Act of Michigan). Among additional members are the State Health Commissioner and the Director of the State Mental Health Department.

The Michigan Hospital Advisory Council held its first meeting, December 23, in Governor Sigler's office. The Council's application for survey funds has been approved by the Federal authorities and the survey budget will



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be presented for approval, on the Federal level, early in 1948. When approved, Federal funds will become available for survey work (not for construction of hospitals, as yet).

* * *

Health Insurance.—Sometimes we are inclined to feel that the *interest in health insurance is so universal* that it must be a live topic in every state, and it was reported last year that the proponents of Federal legislation would divert their activities to the States, hoping for success in having States enact legislation of this character. It would have its effect ultimately on the Congress. The logical approach was on the basis of cash sickness and unemployment sickness benefits, somewhat after the style that prevails in Rhode Island, and has been sponsored by the Governor of California. A survey of the accomplishments of the legislatures of 1947 shows that the interest is far from universal. According to a survey made by the Research Council for Economic Security, Chicago; 50 bills were introduced in all of the state legislatures, and 20 of these were before the New York State Legislature. Massachusetts had 7; New Jersey, 5; Connecticut, 4; Pennsylvania and Washington, 2 each; and 10 other states had one bill each, and they were located in the far West and the North Central, with Alabama as an exception. No such legislation was proposed in the other thirty-two states.

YOUR PHOTOGRAPH

Joseph Merante, Jr., portrait photographer, 475 Fifth Ave., New York, will visit Michigan beginning January 2 to take photographs of additional members of the Michigan State Medical Society. Without any obligation to the individual member or to the Michigan State Medical Society, Mr. Merante has agreed to furnish a glossy print of the portrait of every member of the State Society who sits for a photograph. Through this arrangement, the MSMS archives will include a photograph of every member in the State, eventually. The cooperation of the membership is invited.

Legislation of interest to physicians, passed in Michigan during the year 1947:

A law requiring annual registration of both dentist and dental hygienist, Public Act No. 205.

A law requiring the licensing of hospitals caring for mentally diseased persons and for insane, epileptic or feeble-minded persons or persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants. Public Act No. 106.

A law authorizing the state commissioner of health to promulgate rules and regulations controlling the humane use of animals for the diagnosis and treatment of human and animal diseases, the advancement of veterinary, dental, medical and biologic sciences, and the testing and diagnosis, improvement and standardization

Say you saw it in the Journal of the Michigan State Medical Society

of laboratory specimens, biologic products, pharmaceuticals. The law further required that no person, firm or corporation shall keep or use animals for experimental purposes unless registered to do so by the state commissioner of health. Public Act No. 241.

A law provided for the appointment of a commission to survey the procedure concerning the commitment and care of mentally ill persons. Mich. Acts 1947.

A law designated to enable hospitals to take advantage of the provisions of the federal hospital construction act. This act followed quite closely the model law prepared by the Council of State Governments in that they required a survey of hospital facilities in the state and the preparation of a program for the construction of additional needed facilities.

The laws also required the appointment of an Advisory Hospital Council. Public Act No. 229.

* * *

VA Hometown Pharmacists' Service.—The Michigan State Pharmaceutical Association has a state-wide plan whereby World War II veterans with service-connected disabilities may receive prescription service at government expense from hometown pharmacists of their choice upon authorization of physicians approved by the Veterans Administration.

The fee-basis or designated physician should feel free to patronize these approved pharmacists in order to avoid undue delay to the veteran in receiving his medication. The requirement of the physician is as simple as writing a prescription for any other patient. When authorization has been granted to the physician to render medical service to a Veterans Administration beneficiary and the type of medication needed is determined, all that is required is the name of the veteran, his address, and, if possible, his claim number on the physician's own prescription blank with the following legend over his signature: "I am authorized by the Veterans Administration to treat and prescribe for the above-named Veterans Administration patient." This statement may be printed, written, typed, or stamped on either side of the prescription blank. This prescription cannot be refilled except upon a new prescription from the prescribing physician.

In addition to the medication needed, the following listed items have been approved and designated as "medical requisites" which may be obtained through this service:

1. Insulin syringe and two (2) needles
2. Two (2) hypodermic (insulin type) needles
3. Atomizer
4. Nebulizer
5. Hot water bottle
6. Fountain syringe
7. Combination hot water bottle and syringe
8. Ice bag
9. Ice cap
10. Urinal
11. Bedpan
12. Enema can
13. Feeding tube
14. Ear and ulcer syringe

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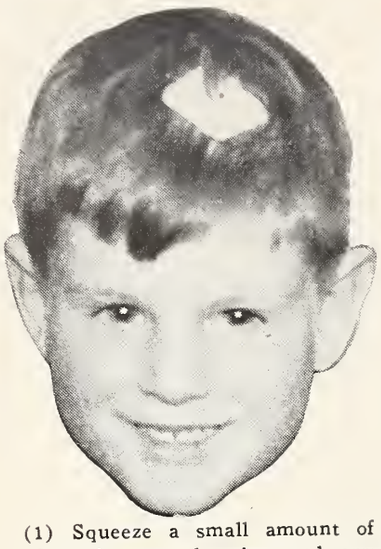
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and will be issued only upon presenting a new prescription written by the prescribing physician. Prescriptions for medical requisites must be for a single item, must bear name and address of the veteran with a signed statement of authorization of the prescribing physician.

Other medical requisites, such as gauze, bandages, adhesive tape, elastic stockings, supporters, etc., may be obtained by a written prescription when submitted to the nearest Veterans Administration regional office. They cannot be obtained through the pharmaceutical association's state-wide plan.

* * *

Slight Case of "Stomach Trouble"

Radiologic evidence of a fork removed from the stomach of a Navy veteran, Joseph Lobner, according to a report by James M. Sullivan, M.D., attending consultant in general surgery, Veterans Administration Center, Wood, Wisconsin, and Willard B. Ross, M.D., of Milwaukee, Wisconsin, in a recent issue of the *Wisconsin State Medical Journal.* The patient's only symptoms were "stomach trouble" for three years, with loss of weight and hematemesis. He cannot account for the fork.



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OBSTETRICS—Intensive course, two weeks, starting March 15, April 12.

MEDICINE—Intensive course, two weeks, starting April 26.
Personal course in Gastroscopy, two weeks, starting March 29, April 19.
Electrocardiography & Heart Disease, four weeks, starting February 16, May 3.

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HISTORY OF MEDICINE. A Correlative Text, Arranged According to Subjects. By Cecelia C. Mettler, A.B., Ed.B., A.M., Ph.D. Late Associate Professor of Medical History, University of Georgia School of Medicine, and Late Associate in Neurology, College of Physicians and Surgeons, Columbia University. Edited by Fred A. Mettler, A.M., M.D., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University. 1104 Pages with 16 Illustrations. Philadelphia: The Blakiston Company, 1947. Price $8.50.

This is a very complete volume, two columns to the page, and 1104 pages of text. This is a history of the various phases of medicine, starting with a history of Anatomy and Physiology to the middle ages. It treats of the subject in Egypt, Syria, Persia, the Orient, gives names of persons and a little sketch of what they did, or their influence on the advancement of the subject under discussion. Next is Anatomy to the modern period, then Physiology, Pathology, Bacteriology, Physical Diagnosis. Then follows a history of the specialties, each carried from the first primitive stages down to the present time, giving names, and short notes: Medicine, Neurology and Psychiatry, Venereology, Dermatology, Pediatrics, Surgery, Obstetrics and Gynecology, Ophthalmology, Otology and Laryngology. These are very complete. The book has forty pages of index of names mentioned in the text with a subject index of seventy pages. This is one of the most detailed histories we have ever seen and would make an invaluable reference for research. The progress of knowledge in almost any medical subject could be followed.

THE FOOT AND ANKLE. Their Injuries, Diseases, Deformities and Disabilities. By Phillip Lewin, M.D., F.A.C.S., Associate Professor of Bone and Joint Surgery, and Acting Head of Department, Northwestern University Medical School; Professor of Orthopedic Surgery, Postgraduate Medical School of Cook County Hospital; Attending Orthopaedic Surgeon, Cook County Hospital; Senior Attending Orthopaedic Surgeon, Michael Reese Hospital, Consulting Orthopaedic Surgeon, Municipal Contagious Disease Hospital, Chicago; formerly Colonel, Medical Corps, Army of the United States. 389 illustrations. Line drawings by Harold Laufman, M.D., F.A.C.S., Associate in Surgery, Northwestern University Medical School; formerly Major, Medical Corps, Army of the United States. Third edition, thoroughly revised. Philadelphia: Lea & Febiger, 1947. Price $11.00.

Dr. Lewin, in dedicating his book "The Foot and Ankle" to Dr. Allen B. Kanavel, has tried to do for the foot what Dr. Kanavel did for the hand. Undoubtedly, after reading it, everyone will agree that he has amply met all of Dr. Kanavel's requirements.

This third edition is greatly enlarged over the previous ones and is adequately illustrated throughout. Numerous outlines and charts, framed to attract the eye of the reader, are extremely helpful when using this book for reference. The "Pedigrams" in the appendix are clever sayings, all of which have a point to be remembered.

This volume of 800 pages begins with an adequate discussion of the embryology and anatomy of the foot and ankle, continues with physiology, biochemistry and then, in detail, goes into the specific deformities and afflictions of the foot and ankle. Several chapters are allotted to the effects of trauma, and the latest methods for the

handling of fractures and dislocations are discussed in detail. Reconstructive surgery has been given a prominent place. Infections, metabolic disorders and tumors are all carefully and thoroughly discussed. There is no condition involving the foot, seen by the general practitioner or the specialist, that is not fully discussed by Dr. Lewin. This volume should be considered a "must" for every medical library.

P.C.K.

FUNDAMENTALS OF PSYCHIATRY. By Edward Strecker, M.D., Sc.D., LL.D., Litt.D., F.A.C.P. Professor of Psychiatry and Chairman of the Department, Undergraduate and Graduate Schools of Medicine, University of Pennsylvania; Psychiatrist to the Pennsylvania, Philadelphia and Germantown Hospitals; Consultant and Chief of Service, Institute of the Pennsylvania Hospital,, Consultant to the Surgeon General, U. S. Navy; Formerly Consultant for the Secretary of War to the Surgeons General of the Army and AAF Senior Consultant in Psychiatry, Veterans Administration; Consultant in Mental Hygiene, USPHS Chairman Committee on Psychiatry, National Research Council, and American Red Cross. Fourth Edition. 21 Illustrations. Philadelphia: J. B. Lippincott Company, 1947. Price $4.00.

This book is one of a group designed to make the practice of medicine in various groups of diseases more exact, by providing the commoner and more accurate facts and theories. The teaching is partly by case reports which are well presented with much detail, so that the practitioner or the student will have something definite to grasp. This is a fourth edition and has been extensively revised. Space is given to the war neuroses and relations of psychiatry to the many manifestations found. The book is small but complete, in so far as possible in a monograph. The work, which is the free expression of an able teacher and his experiences, is well worth while.

PHYSIOLOGY OF MAN IN THE DESERT. By E. F. Adolph, Ph.D., Associate Professor of Physiology, University of Rochester; and Associates. New York: Interscience Publishers, Inc., 1947. Price $6.50.

This monograph of over 350 pages contains the studies and deductions from work done under a contract recommended by the Committee on Medical Research, between the United States Office of Scientific Research and Development, and the University of Rochester School of Medicine and Dentistry. The project was undertaken to determine the reactions and resistance of man living in the desert. Elaborate studies were made of water balance, requirements under desert or heat conditions, and what would be the result of deficiencies. Heat exchanges, rates of sweating with salt and water losses, and tolerance were studied. Urinary contents and secretions are a part of the whole problem, as are also the blood and its chemistry. There is also a comparison of man on a raft and man in the desert. This is a very valuable contribution to our knowledge, and will have its influence on treatment of certain deficiencies.

INFANT NUTRITION, A TEXTBOOK OF INFANT FEEDING FOR STUDENTS AND PRACTITIONERS OF MEDICINE. By P. C. Jeans, A.B., M.D., Professor of Pediatrics, College of Medicine State University of Iowa, Iowa City, and Williams McKim Marriott, B.S., M.D., Late Professor of Pediatrics, Washington University School of Medicine; Physician in Chief, St. Louis Children's Hospital, St. Louis. Fourth edition. St. Louis: The C. V. Mosby Co., 1947. Price $6.50.

Numerous changes have been made in this new edition of a work which has long been standard in its class. While it is impossible for any textbook to keep com-



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pletely abreast of new information in this rapidly changing field, the revision accomplished by the author is of sufficient thoroughness that it insures the essential authority and modernity of the work.

Particularly commendable is the conservative attitude the text exhibits toward subjects now in considerable controversy. For instance, no great emphasis is placed on a rigid feeding schedule without going the entire route toward so called "demand feeding." The chapter on "Vitamins" is especially valuable, and the one detailing "Miscellaneous Techniques" is very practical.

It is difficult to see how any physician whose practice includes the care and feeding of infants and children can properly perform his duty without the information contained in such a text as this at his elbow.

H.F.B.

FUNDAMENTALS OF IMMUNOLOGY. By William C. Boyd, Ph.D., Associate Professor Biochemistry, Boston University School of Medicine, Second edition, completely revised and rewritten. New York: Interscience Publishers, Inc., 1947. Price $6.50.

The second edition of "Fundamentals of Immunology like the first, is addressed to medical students and those interested in research. The author states it is not the purpose of the book to be exhaustive but rather to cover the fundamentals of immunology, as the title implies. This latter accomplishment the author does very well in a way that makes an exceedingly complex subject matter appear remarkably clear to the reader. The author does not sacrifice detail and thoroughness in covering the subject matter for clarity but rather it is presented in a way that makes the volume an excellent reference book for the research worker, student or the practicing physician.

While no busy practicing physician would be inclined to spend an evening or two reviewing this subject matter as easy reading, the book does have a place in the physician's library for refernce or for reviewing a chapter from time to time.

Ample references are supplied in case the reader wishes to investigate more thoroughly any work or studies referred to in the text.

G.A.Z.

SEXUAL BEHAVIOR IN THE HUMAN MALE. By Alfred C. Kinsey, Professor of Zoology, Indiana University; Wardell B. Pomeroy, Research Associate, Indiana University; and Clyde E. Martin, Research Associate, Indiana University. 804 pages—173 charts—159 tables. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.50.

This volume is presented as a factual study of sexual behavior in the human male. It is based on 12,000 case histories with particular reference to the data on 5,300 males. Many medical, psychiatric and educational groups as well as penal and other institutions have contributed to the enormous amount of material correlated and presented by the authors. This is essentially a reference book, the first in a series which will add materially to our understanding of sex behavior. The book is divided into three main parts: (1) History and Method; (2) Factors Affecting Sexual Outlet and (3) Sources of Sexual Outlet. No moral evaluation is attempted. Necessarily a large amount of the data is presented in tables and graphs, but there is also an adequate discussion of

each problem which can arise in the sexual behavior of the male. This is not a book for the general practitioner, but is of value to the psychiatrist, medical social worker, sociologist or psychologist. This book has attracted comment from various lay reporters, and has caused the writing of at least one more or less sensational story.

D.K.H.

GEORGE CRILE. An Autobiography. Edited, with Sidelights by Grace Crile. In two volumes. Philadelphia and New York: J. B. Lippincott Company, 1947. Price $10.00.

George Crile was a prolific writer and soon after their marriage, Mrs. Crile began collecting his papers of every description. She accumulated thirty-four volumes, five hundred or more pages of manuscripts, fifty diary files of three to five hundred pages, thirty-eight volumes of war diaries, and eleven volumes of reprints. This, together with her personal notes, memories, and life experiences has given a most unusual source of material, and the two volumes that have resulted are a wonderful fund of lore to delight Dr. Crile's friends and admirers.

Most of the work is in the first person, but Crile's style is well known to so many who have known him, and read his every work that this opens up a new treasure. You will like the books.

PRACTICAL CHILD GUIDANCE. By Samuel Kahn, M.D., Ph.D.; Grace Kirsten, A.B.; and May Elish March, A.B., M.A. Samuel Kahn is Adjunct Professor of Psychology and Psychiatry at Long Island University; Grace Kirsten, formerly New York City Department of Education and Lecturer on Child Guidance; May Elish March, formerly a teacher in the New York City High Schools. Boston: Meador Publishing Company, 1947. Price $4.00.

Child guidance is gaining in importance with the years and with experience. This book is an attempt to give the best of these teachers' experiences in the question and answer form. That method of approach allows a coverage without limit, and lets the authors lead into the most intriguing methods, but the continuity of interest, as in a story form of instruction is lost. This book is written for use of the parent and teacher more than the professional consultant, but anyone who must give advice in child guidance will find it a useful reference. Young parents can be assured of proper and explained advice. The reasons for actions and conclusions are carefully given.

THE METROPOLITAN LIFE. A Study in Business Growth. By Marquis James, twice Pulitzer Prize winner; author of The Raven, A Biography of Sam Houston, Andrew Jackson—Portrait of a President, et cetera. New York: The Viking Press, 1947. Price $5.00.

Mr. James is a fluent and easy writer, very interesting, very stimulating and his latest book, "The Metropolitan Life," gives us the history of the development of insurance from the time of the Phoenicians and Greeks, who insured their boats and cargoes as far back as 1000 B.C. The idea of insuring life started with annuities, and was based on Roman law under Emperor Alexander which fixed life expectancy. Trial and error, experience and failure built up the insurance business. Reading this book makes those of us in Michigan who helped to develop Michigan Medical Service wish this book had been written at least nine or ten years ago. We would have been saved much groping. The book is a pleasure to read and gives the history of the Metro-

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PRACTICAL X-RAY TREATMENT. By Arthur Erskine, M.D. Third edition, revised and enlarged. Saint Paul and Minneapolis: The Bruce Publishing Company, 1947. Price $4.50.

Fully one-half of this book is devoted to a thorough review of the physical factors involved in the use of x-ray for therapy. While all of the physical aspects cannot be covered in a few pages, the survey is adequate for one who already has some knowledge of the subject and will serve to urge the uninitiated to dig further into the subject before buying a therapy unit and blithely going ahead. And, is not that the purpose of any treatise?

The last half of the book is devoted to a rapid survey of the conditions for which x-ray therapy has been used.

While, as Dr. Erskine says in his preface, this text is not intended for the use of men well qualified in the field of roentgen therapy, it is an excellent sign board for men contemplating work in this field.

G.T.P.

FORMULARY. University of Michigan, Ann Arbor. Second edition. Ypsilanti: University Lithographers, Inc., 1947. Price $3.75

This volume contains the formulae and remedies used at the University Hospitals, giving their preparation, use and dosage. The first part of the book contains tables for conversion, apothecary and metric measure, and instruction for prescription writing. The medical agents are grouped under amino acids, antihistamine drugs, anti-infectives, autonomic, cardiovascular, central nervous system depressants, et cetera, up to vitamins. It is a pocket size book and should prove very useful.

A TEXTBOOK OF CLINICAL NEUROLOGY WITH AN INTRODUCTION TO THE HISTORY OF NEUROLOGY. By Israel S. Weschler, M.D., Clinical Professor of Neurology, Columbia University, New York; Neurologist, The Mount Sinai Hospital; Consulting Neurologist, Montefiore Hospital and Rockland State Hospital, New York. Sixth edition, illustrated. Philadelphia: W. B. Saunders Co., 1947. Price $8.50.

This most recent revision emphasizes again the fact that this book is a valuable reference work for the busy practitioner. It emphasizes also that clinical neurology is a living and progressive specialty. The material presented in the introductory chapters having to do with anamesis can add much to the clinical and diagnostic approach to most any patient. The chapter on neurosis is well written and can be recommended for a summary of a controversial subject.

The chapter on psychological diagnosis is an outstanding portion of this book. It can be recommended to the physician, the student, and allied workers in the field of neuro-psychiatry. In this chapter, the exact place of the psychologist, as well as the value and the limitations of psychological evaluation of the patient, is presented in an unequivocal and direct fashion.

In general, the book is so organized that with the help of the references in the text, the index and table of con-

Say you saw it in the Journal of the Michigan State Medical Society

tents, desired information is easily and quickly located. The various clinical entities and syndromes provide a maximum of clinical information without burdensome theoretical considerations. In the opinion of this reviewer the author has, to a large extent, fulfilled his intentions in making this "book a fairly complete repository of as much factual clinical neurology as can reasonably be gathered between two covers."

F.O.M.

TWENTIETH ANNIVERSARY YEAR OF HAROFE HAIVRI, The Hebrew Medical Journal. A semiannual bilingual publication edited by Moses Einhorn, M.D.

In the medical section, the following subjects are offered: "The Importance of the Rh Factor in Clinical Medicine" by Philip Levine, M.D., and Pharmacology and Toxicology of Streptomycin" by Ernest Pick, M.D.

The section on Palestine and Health contains the following articles: "The Contribution of Bacteriologists for the Control of Infectious Diseases in Palestine" by L. Olitzki, M.D., of the Hebrew University; The Present Status of Tuberculosis in Palestine" by A. Wolowelsky, M.D., and "Plastic Surgery in Palestine" by Ernest Wodak, M.D.

Under the heading of Historical Medicine, Dr. Leon Nemoy of Yale University writes on the great philosopher and physician of the 13th century—Ibn Kammuna. Dr. Yom-Tov Levinsky discusses in his article on Folklore Medicine, the legends surrounding frogs and spiders as healing agents.

Original articles are summarized in English to make them available to those who are unable to read Hebrew.



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MSMS County Secretaries - Public Relations Conference

January 25, 1948



J. Bates Henderson, M.D., of Sebewaing, long-time secretary of the Huron County Medical Society, was chosen as chairman of county society secretaries at the Annual County Secretaries-Public Relations Conference held at the Book-Cadillac Hotel, Detroit, on Sunday, January 25, 1948.

One hundred eighty-seven were in attendance and heard an intensely and enlightening program presided over by D. Bruce Wiley, M.D., of Utica, who served as chairman during the past year.

The meeting opened with "What the Voluntary Program Has Accomplished in the Distribution of Medical Service" presented by R. L. Novy, M.D., Detroit, President Michigan Medical Service. A "Warning from Washington" was given by Wilfrid Haughey, M.D., Battle Creek, MSMS Councilor and Editor, JMSMS.

E. F. Sladek, M.D., Traverse City, MSMS President-Elect, gave a stirring twenty-minute message entitled "Making Friends for Medicine." The morning session was closed with a remarkably lucid presentation entitled "We, the Doctors," by R. M. Klemme, M.D., St. Louis, Mo., Professor of Neurosurgery, St. Louis School of Medicine.

Elmer Hess, M.D., Erie, Pa., President of the Medical Society of the State of Pennsylvania, was the noon-day dinner speaker. He was introduced by MSMS President, P. L. Ledwidge, M.D., Detroit, and spoke with telling force on the subject "The Physician Looks at the Future."

In the afternoon the group divided into two meetings. The county secretaries entered a panel on county medical society organization with Council Chairman, O. O. Beck, M.D., Birmingham, as Moderator. Participants were: H. W. Porter, M.D., Jackson; C. D. Otto, Lansing; J. K. Altland, M.D., Lansing, and J. S. DeTar, M.D., Milan.

The panel on media, arranged for public relations chairmen, was handled by L. W. Hull, M.D., Detroit, Chairman of the MSMS Public Relations Committee. Participating were Arthur L. Snider, Chicago, Science Writer of *Chicago Daily News;* Edgar A. (Bud) Guest, Jr., of WJR, Detroit; Wm. J. Hedges, Detroit, of Jam Handy Associates, and Minita Westcott, Chicago, President American Trade Association Executives.

The thirty-six County and District Secretaries and Executive Secretaries present at the Conference were:

E. W. Blanchard, M.D., Sanilac; J. Russell Brink, M.D., Kent; Herman R. Brukardt, M.D., Menominee; Daniel M. Clarke, M.D., Barry; R. C. Conybeare, M.D., Berrien; Dean T. Culver, M.D., Branch; E. W. Fitzgerald, M.D., St. Clair; L. Fernald Foster, M.D., Bay; G. Fredrickson, M.D., Dickinson-Iron; M. R. French, M.D., Van Buren; Harold L. Gordon, M.D., Midland; C. L. Grant, M.D., Manistee; L. E. Grate, M.D., Northern Michigan; Ernest P. Griffin, Jr., M.D., Genesee; J. Bates Henderson, M.D., Huron; L. Dell Henry, M.D., Washtenaw; T. Y. Ho, M.D., Clinton; Theo. E. Hoffman, M.D., Tuscola; Kenneth H. Johnson, M.D., Ingham; Harold Kessler, M.D., Alpena-Alcona-Presque Isle; John H. Kitchel, M.D., Ottawa; Arthur J. Klippen, M.D., Saginaw; William M. LeFevre, M.D., Muskegon; O. R. MacKenzie, M.D., Oakland; James E. Mahan, M.D., Allegan; J. J. McCann, M.D., Ionia-Montcalm; H. R. Moore, M.D., Newaygo; P. J. Murphy, M.D., Houghton-Keweenaw-Baraga; Carl A. Peterson, M.D., Hillsdale; Donald G. Pike, M.D., Grand Traverse-Leelanau-Benzie; H. W. Porter, M.D., Jackson; E. C. Texter, M.D., Wayne; J. A. White, M.D., Mecosta-Osceola-Lake; D. Bruce Wiley, M.D., Macomb; Executive Secretaries Sara M. Burgess, Genesee, and Else Kolhede, Wayne.

Presidents and Presidents-Elect of County Medical Societies who attended were:

Hugo Aach, M.D., Kalamazoo; Howard B. Barker, M.D., Oakland; George W. Bennett, M.D., Shiawassee; E. T. Brunson, M.D., Allegan; Clarence L. Candler, M.D., Wayne; A. M. Crawford, M.D., Macomb; Clarke Dorland, M.D., Lapeer; S. W. Hartwell, M.D., Muskegon; Frank D. Johnson, M.D., Genesee; J. W. O'Neill, M.D., Newaygo; Harry A. Towsley, M.D., Washtenaw; John A. MacNeal, M.D., Hillsdale; Harold H. Hiscock, M.D., Flint; Douglas Donald, M.D., Detroit.

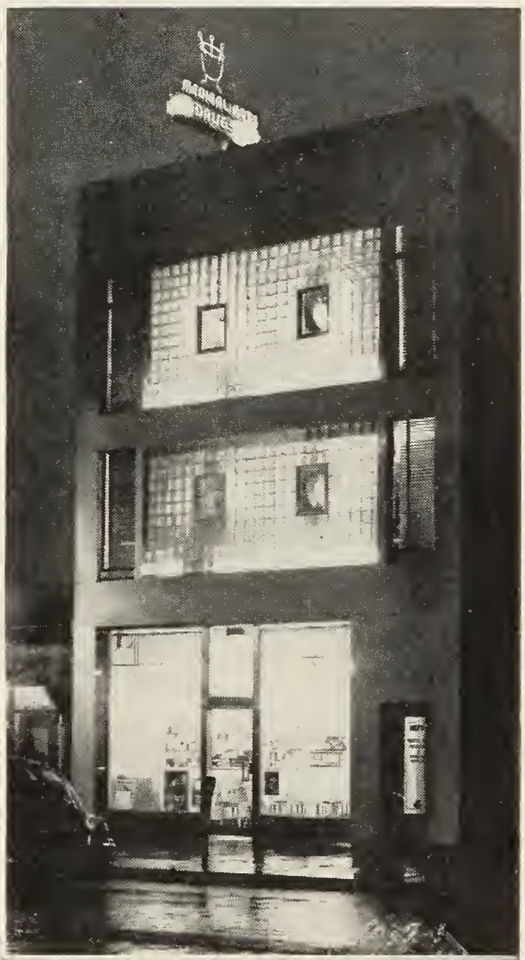
Representatives of the Woman's Auxiliary, totaling twenty-five, were present:

Mrs. T. Grover Amos, Detroit; Mrs. C. J. Barone, Wayne; Mrs. Robert Breakey, Ingham; Mrs. Martin F.

(Continued on page 244)

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(Continued from Page 242)

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MSMS officers who attended included:

President, P. L. Ledwidge, M.D.; President Elect, E. F. Sladek, M.D.; Secretary, L. Fernald Foster, M.D.; Treasurer, A. S. Brunk, M.D.; Speaker, J. S. DeTar, M.D. and Councilors, W. E. Barstow, M.D., O. O. Beck, M.D., T. E. DeGurse, M.D., Fred Drummond, M.D., W. H. Huron, M.D., J. D. Miller, M.D., E. A. Oakes, M.D., C. E. Umphrey, M.D.; and Past Presidents, Robert R. Scott, M.D. and J. M. Robb, M.D. Councilor, R. J. Hubbell, M.D.; Wilfrid Haughey, M.D., Editor JOURNAL of the Michigan State Medical Society; MSMS Past Presidents, B. R. Corbus, M.D., Grand Rapids; L. S. Hirschman, M.D., Detroit, and J. M. Robb, M.D., Detroit.

The thirty-one Public Relations Committee representatives present were:

Robert J. Albi, M.D., Northern Michigan; C. Allen Payne, M.D., Kent; S. E. Andrews, M.D., Kalamazoo; Harry Berman, M.D., Tuscola; A. F. Bliesmer, M.D., Berrien; Martin F. Bruton, M.D., Saginaw; Thomas N. Eickhorst, M.D., Genesee; George B. Finch, Detroit; W. G. Gamble, M.D., Bay; Edgar A. Guest, Jr., WJR, Detroit; Leslie T. Henderson, Wayne; K. P. Hodges, M.D., Ingham; Leland E. Holly, M.D., Muskegon; L. W. Hull, M.D., Wayne; Robert J. Jermstad, M.D., Genesee; John S. Lambie, M.D., Oakland; James Lightbody, M.D., Wayne; Jackson Livesay, M.D., Genesee; Robert K. Mason, Grand Rapids; E. B. Miller, M.D., Manistee; Fred R. Reed, M.D., St. Joseph; W. Z. Rundles, M.D., Genesee; R. F. Salot, Macomb; L. C. Salter, Chicago; G. B. Saltonstall, M.D., Northern Michigan; Vergil N. Slee, Barry; Arthur J. Snider, Chicago; A. H. Steele, M.D., Van Buren; R. Wallace Teed, M.D., Washtenaw; Arch Walls, M.D., Wayne, and Claude L. Weston, M.D., Shiawassee.

The thirty Health Officers who attended were:

J. K. Altland, M.D., State Health Commissioner, Ingham; Arthur G. Baker, M.D., Allegan; Charles J. Barone, M.D., Wayne; C. D. Barrett, M.D., Wayne; C. Dale Barrett, Jr., M.D., Ottawa; C. C. Benjamin, M.D., St. Clair; L. V. Burkett, M.D., Genesee; Ernest A. Cook, M.D., Shiawasee; Goldie B. Corneliuson, M.D., Ingham; Carleton Dean, M.D., Ingham; Bruce H. Douglas, M.D., Wayne; Otto K. Engelke, M.D., Washtenaw; Robert F. Hall, M.D., Isabella; George Hays, M.D., Genesee; Albert Heustis, M.D., Branch; R. Lanting, M.D., Ingham; F. S. Leeder, M.D., Ingham; David Littlejohn, M.D., Wayne; A. F. Litzenburger, M.D., Northern Michigan; R. L. Loftin, M.D., Bay; E. J. MacLachlan, M.D., Jackson; G. F. Moench, M.D., Hillsdale; John D. Monroe, M.D., Oakland; Charles A. Neafie, M.D., Oakland; Frank A. Poole, M.D., Saginaw; W. B. Prothro, M.D., Kalamazoo; Oscar D. Stryker, M.D., Macomb; George C. Stucky, M.D., Eaton; L. W. Switzer, M.D., Manistee; and V. Volk, M.D., Saginaw.

Others who attended included:

T. G. Amos, M.D., Detroit; Howard Brower, of Council on Medical Service, AMA, Chicago; William H. Byrne, Detroit; E. I. Carr, M.D., Lansing; John W. Castellucci, Detroit; Joe A. Clark, Executive Secretary State Medical Association of Texas, Ft. Worth, Texas; Arthur Clements, Detroit; George W. Cooley, Council on Medical Service, AMA, Chicago; John A. Cowan, M.D., Lansing; E. B. Cudney, M.D., Pontiac; Louis J. Gariepy, M.D., Detroit; James L. Gillard, M.D., Muskegon; John Gray, Lansing; Genevieve Grotz, M.D., Detroit; T. K. Gruber, M.D., Eloise; Elmer Hess, M.D., Erie, Pa.; Henry S. Hosmer, Michigan Medical Service, Detroit; Mrs. L. W. Hull, Detroit; Jay C. Ketchum, Michigan Medical Service, Detroit; R. M. Klemme, M.D., St. Louis, Mo.; Harry R. Lipson, Highland Park; K. E. Markuson, M.D., Lansing; William S. McNary, Michigan Hospital Service, Detroit; Robert C. Monson, Detroit; Victor E. Nelson, M.D., Detroit; R. L. Novy, M.D., Detroit, C. W. Otto, Lansing; F. L. Rector, M.D., Ann Arbor; Patricia Salter, Chicago; C. E. Simpson, M.D., Detroit; Edward T. Torwick, M.D., Jackson; Roger V. Walker, M.D., Detroit; Minita Westcott, Chicago; Wm. S. Hedges, Detroit; and Lawrence C. Salter, Chicago.



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Cameron, A. T.: Recent Advances in Endocrinology, ed. 5, Philadelphia, The Blakiston Company, 1945, p. 1.

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Community Enrollment

Doctors and hospital administrators of Clinton County, Michigan, sponsored a Blue Cross community enrollment in their county last month in order to bring the prepaid hospital and surgical care services of Michigan Medical Service and Michigan Hospital Service to the man and woman not eligible to join Blue Cross through an employe group.

Blue Cross is ordinarily available only to those persons who work where there are five or more employes or who belong to such organizations as Farm Bureaus, Granges, or certain professional associations protected by the plan.

Co-operating in the county-wide Blue Cross enrollment were Chester E. Teske, Superintendent of Clinton Memorial Hospital; W. B. McWilliams, M.D., Chief of Staff doctors of that hospital; and S. R. Russell, M.D., President of the Clinton County Medical Society.

A five weeks' drive followed, with community enrollment headquarters being opened in DeWitt, Elsie, Fowler, Maple Rapids, Ovid, St. Johns and Westphalia. Organizations and clubs in these communities, together with civic leaders, were contacted for the purpose of building interest in the campaign.

Newspaper stories of the Blue Cross program were used in every newspaper in Clinton County. Distribution of folders in all the schools of the county, announcements through the churches, theater announcements, display windows at the various headquarters, posters displayed throughout the business districts, and door-to-door personal contacts were other media through which the public was acquainted with the enrollment.

Of significance to the campaign was the interest expressed by the Clinton County Farm Bureau. As farmers came to enrollment headquarters to inquire about Blue Cross, they were encouraged to join discussion groups within their Farm Bureau, which, in turn, would make them eligible for enrollment under the group plan which provides broader protection at cheaper subscription rates.

As the campaign continued, there was pronounced interest among business and industrial groups. Prior to the drive, only seven industrial or small business groups in the entire county were enrolled in Blue Cross. Before the campaign had ended, eight new groups had been enrolled and more than twenty others indicated a desire to enroll.

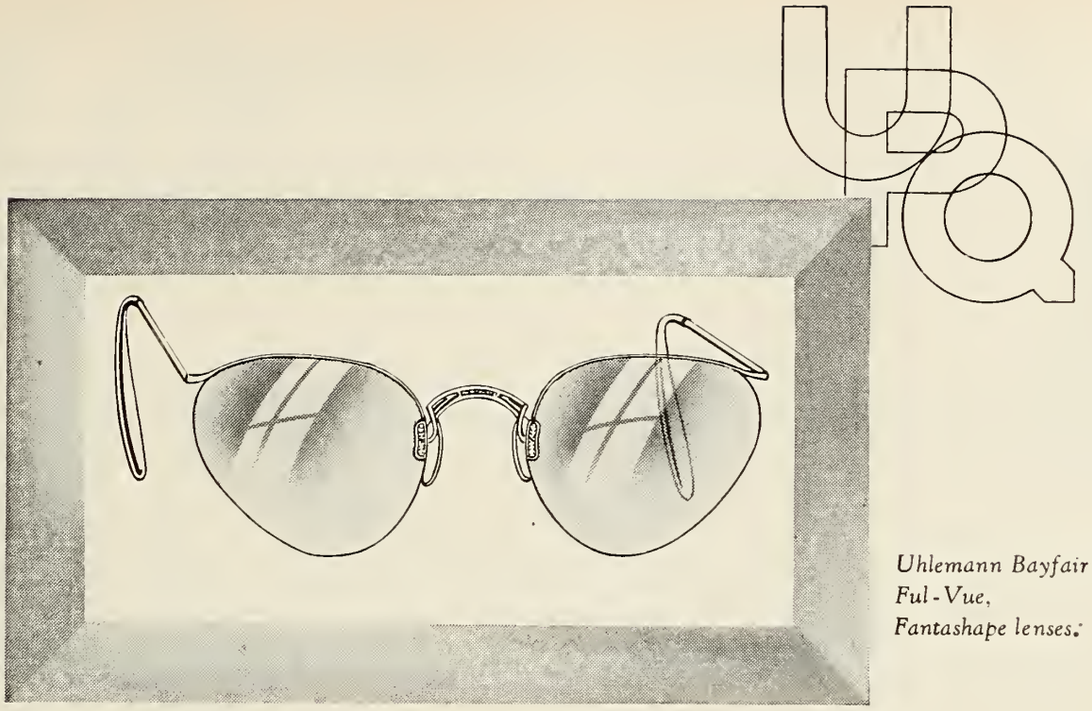
In evaluating the campaign, it is apparent that the public is becoming aware of the benefits of the modern hospital and of the value of early surgical and medical care for sickness. Those who are self-employed, retired, or engaged in occupations where the number of employes prohibits the privilege of group enrollment were able to get Blue Cross protection on a basis comparable, with few restrictions, to the benefits extended to employed groups on a payroll deduction plan.

Second, the doctors and the hospital officials sensed a public interest in the service they made possible to the people of the community. This was sound public relations policy.

Finally, Blue Cross, which is truly a public service organization, has given further impetus to a common interest of the doctors, the hospitals and the general public in making it possible for individuals to secure the benefits of a prepaid plan of protection against health misfortunes.

Other Blue Cross community enrollment campaigns will be planned and executed as public interest and co-operation of Michigan hospitals and doctors develop, Klein said. (See page 248.)





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DOCTOR . . . WHAT NEW BELIEFS AND FRIENDSHIPS for you . . . . when you carefully, slowly fit the new glasses to your patient's face and eyes . . . . . and he looks up, with all his worries gone, and smiles and says: "Fine, doctor! I didn't think *I'd ever* see this well again!"

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. . . . . that your patients may *always* spread the news of your understanding skills and abilities to their families, neighbors, friends . . . that *their* beliefs and friendships may grow greater . . . that *your* good reputation may spread and grow *satisfyingly.*

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ESTABLISHED 1907

Say you saw it in the Journal of the Michigan State Medical Society

E. F. Sladek, M.D. Honored



E. F. SLADEK, M.D., Traverse City, President-Elect of the Michigan State Medical Society, was chosen President of the National Conference on Medical Service by popular acclaim, at the annual meeting in the Palmer House, Chicago on February 8. A rising vote of thanks was extended to Dr. Sladek for his development of an outstanding program heard at the Conference's 21st Meeting by 257 registrants, including top officials of the American Medical Association, of state medical associations, deans of medical colleges, and other practitioners of medicine interested in the socio-economic aspects of Medicine.

John S. Bouslog, M.D., Denver, was selected as Secretary for the ensuing year. Besides Drs. Sladek and Bouslog, other members of the Executive Committee are Creighton Barker, M.D., New Haven, Conn.; Frank J. Elias, M.D., Duluth, Minn., Wm. D. Stovall, M.D., Madison, Wis.; Chas. Pfeiffer, M.D., Chicago; J. D. McCarthy, M.D., Omaha, Nebr.; D. H. Murray, M.D., Napa, Calif.; C. L. Palmer, M.D., Pittsburgh; C. A. Nafe, M.D., Indianapolis; B. E. Pickett, Sr., M.D., Carrizo Springs, Texas, and Walter E. Vest, M.D., Huntington, W. Va.

The papers presented at the 1948 National Conference are to be published in THE JOURNAL of the Michigan State Medical Society. They included two viewpoints on "The Practice of Medicine by Hospitals, Health Departments, and Medical Schools" by Everett W. Jones, Chicago, and Lowell S. Goin, M.D., Los Angeles; "Medical Public Relations Begins in the Doctor's Office" by L. Fernald Foster, M.D., Bay City; The Nursing Problem in America with the "Educational Aspect" by Thomas P. Murdock, M.D., Meriden, Conn., and the "Service Aspect" by Janet Geisert, R. N., Chicago; "Are Medical Educational Requirements Too High—Should We Have More Doctors?" by Andrew C. Ivy, M.D., Chicago. A Panel Discussion was held on General Practice with "The Need for and Recognition of the General Practitioner" by Wingate M. Johnson, M.D., Winston-Salem, N. Car., and "Methods of Training for General Practice" by C. F. Wilkinson, M.D., Ann Arbor, Mich., and "The Continued Education of our Doctors" by G. L. Schadt, M.D., Springfield, Mass. Discussion of Specialty Boards included "The Objectives and Functions of Specialty Boards with Special Reference to the American Board of Surgery" by J. Stewart Rodman, M.D., Philadelphia.

The 1949 Conference will be held next March at the Palmer House, Chicago.

M. D. Re-enrollment in Blue Cross

Members of the Michigan State Medical Society and their office employes who are not now Blue Cross members will have an opportunity to enroll in the Blue Cross Plans during the month of April.

Medical Society members and their office employes who are already Blue Cross subscribers and who wish to make changes in their hospital-surgical protection may do so during this enrollment period.

Blue Cross enrollments and changes in present service will be accepted until April 20. The effective date of Blue Cross certificates issued as a result of this enrollment will be May 1, 1948.

Every member of the Michigan State Medical Society will be mailed a Blue Cross application card and explanatory literature for himself and for his office employes. If this material is not received, or if additional application cards are needed, they may be obtained from any Blue Cross district office or from state headquarters of the MSMS.

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- No automatic termination age.
- Once policy is issued, it cannot be ridered or amended.
- Premiums waived for total disability.
- You can elect full lifetime benefits for total accident disability instead of a lump sum for loss of both hands, feet or eyes.
- Pays full benefits if injured doing other than your regular work.
- Covers all accidents except private flying — you are covered on the airlines.
- All accident benefits are doubled if you are injured while riding as a fare-paying passenger on a train, streetcar or bus.
- As an individual policy, it can only be canceled for the non-payment of premium or if all like policies were declined in the entire state.
- Pays additional benefits in the hospital or under nurse's care at home.
- Pays accidental death benefit.
- Monthly benefits up to $400 per month.

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WRITE TO PROFESSIONAL DEPARTMENT FOR INFORMATION

Political Medicine

PRESIDENT'S HEALTH PLAN

The President on January 30, 1948 addressed the following letter to the Honorable Oscar R. Ewing, Administrator of the Federal Security Agency:

"Dear Mr. Administrator:

"The health of our people is of such importance to our national welfare and security that I wish to make certain that we are taking all possible steps to contribute to its improvement. I have, as you know, repeatedly requested the Congress to enact legislation designed to expand basic health services and to bring them within the reach of all the people. While such legislation is of primary importance, its enactment alone will not assure that we shall reach the highest possible levels of health. The attainment of such a goal requires the cooperation of State and local governments, voluntary organizations, the medical and health professions, as well as all of our citizens working together.

"Our people want good health and are willing to work to achieve it. Notable progress has already been made. But I am convinced that we have scarcely scratched the surface and that, as a Nation, we can make rapid progress in the immediate future.

"I should like to ask you, therefore, to undertake a comprehensive study of the possibilities for raising health levels and to report to me, at your early convenience, upon feasible goals which might be realized by the American people in the next decade. I should appreciate further any suggestions you may wish to make concerning the most practicable methods of achieving such goals. In preparing this report, you will undoubtedly wish to confer with interested persons both in and out of the Government.

Very sincerely yours,
Harry S. Truman

STATEMENT OF POLICY ON "COMMUNITY HEALTH CENTERS"

The Michigan State Medical Society recognizes the demand for better facilities to meet the medical needs of certain areas of the State.

Whether so-called health centers are to afford even a partial solution of the problem must depend in large measure on two considerations: one, a clear definition of the scope and nature of their functions; and two, the type of control by which their operations are to be governed.

Approval of health centers by The Council of the Michigan State Medical Society should be expected only when their purposes are consonant with the well established democratic principles of private enterprise as applied to the practice of medicine, and whenever the control of their operations is vested in private practitioners of medicine and civic and health agencies of the local community.

ARE WE CONVINCED?

The following editorial is the lead article in the *British Medical Journal,* January 10, 1948. We are copying it to show our members what we may be facing in the near future.

Are We Convinced?

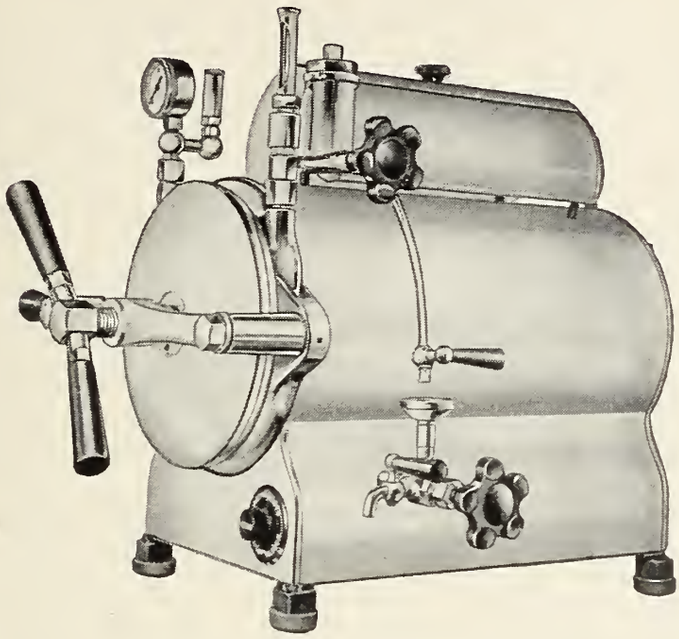
The medical profession has lost little time in making an effective rejoinder to Mr. Bevan's reply to the Negotiating Committee. Our correspondence columns show that doctors are now fully alive to the implications of the National Health Service Act and becoming firm in their resolve to say "No" to a Minister whose method of negotiation is to alternate blandishments with threats in his successful attempt to avoid discussing those matters which the Negotiating Committee consider to be fundamental points of disagreement between the medical profession and the Ministry of Health. The Committee which met the Minister on Dec. 2 and 3 were certainly treated to a brilliant exhibition of dialectical skill. But this was not really the purpose of the meeting with the Minister. The purpose was negotiation, and Mr. Bevan once more proved that his interpretation of the meaning of this word differs from that which is usually accepted.

The expression of opinion in our correspondence columns against service under the Act in its present form received resounding support in two large and important meetings held last week in Wimbledon and B.M.A. House, addressed respectively by Dr. H. Guy Dain, the Chairman of Council, and Dr. Charles Hill, the Secretary of the B.M.A. Loud applause greeted Dr. Dain when he said "we are not prepared to be in a salaried position in which the interference of a State department may come between us and the interests of our patients. With a salary even as small as £300 a year we shall begin to experience control." After a thorough and objective analysis of the Minister's reply Dr. Hill asked, "What does it all add up to?" And he went on:

"There is one criterion by which as a profession we can measure these matters. It is not, I hope, a financial criterion. It is whether these proposals do or do not bring us closer to a whole-time salaried service of the State. That is the crucial issue, and on that issue we can command the support of the overwhelming majority of our profession."

The meeting was the largest that had ever assembled in B.M.A. House, and it listened with close attention to Dr. Hill's reasoned exposition of the case for over an hour. The loud applause which greeted the statement quoted was, therefore, all the more impressive. The Act, Dr. Hill observed, was the first step to the fulfilment of the Socialist programme for a whole-time State Medical Service. The general practitioner in the proposed new Service will be unable to begin work without the permission of a Committee in Whitehall; he will be paid in part by salary, and at any time the Minister by regulation can decree that payment shall be wholly by salary; he will no longer own the goodwill of his practice and will, therefore, lose the plot of ground which in a free society enables him to preserve his freedom as an individual. The consultant and the specialist will have to work in hospitals owned by the Minister of Health, who can under the terms and definitions of the Act at any time take over any institution in which sick persons are being treated. The sign-posts all point in one direction—control of the medical profession by the State. To make quite sure that the reins of control shall be firmly in one pair of hands, the Minister insists upon the appointment by him of the Chairmen of various administrative committees down to the Local Executive Council. On Monday this week he sent a letter to the Secretary of the Negotiating Committee asking the B.M.A. to propose names for the members of

(Continued on Page 252)



HP AUTOCLAVE

The HP is a completely self-contained unit requiring no special plumbing or installation cost. It is equipped with reservoir condenser, automatic discharge and safety valves, pressure and temperature indicators. All controls fully automatic.

The exclusive Pelton reservoir condenser disposes of escaping steam even that which is discharged after sterilizing, converting it into distilled water for use in refilling boiler as required. Inside chamber dimensions are 8" x 16"; overall 22" x 14" x 18". Price $318.50.

MODEL 61 CABINET STERILIZER

The spacious Model 61 Cabinet Sterilizer includes all the outstanding Pelton features, such as cast bronze self-draining boiler, non-dumping tray, and drip-proof cover. The safety cutoff is absolute, consuming no current after engaged.

A hydraulic foot release lowers the tray and cover gently into sterilizing position, and the doubly large storage compartment is automatically illuminated.

The sterilizer is recessed in a Formica top, which is burn and acid proof. The Cabinet measures 35" x 23" x 37" and is priced at $211.00.



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ARE WE CONVINCED?

(Continued from Page 250)

the Medical Practices Committee. This letter is another indication that the Minister has banged the door in the face of the profession and is determined to go on with his Act in spite of the fact that he has failed to secure what he has stated to be indispensable—namely, the co-operation of the doctors of this country. And it is for the doctors of this country to decide whether a medical service begun in this way and initiated by a Minister who has shown himself contemptuously indifferent to reasoned arguments shall come into operation in July this year.

One thing is certain, and that is that the Act cannot come into operation if the large majority of medical men and women stand firmly outside the new Service on July 5. The size of this majority will depend upon the strength of the conviction held that a State Medical Service will be harmful to medicine and therefore to the public which the profession of medicine serves. If the profession is so convinced, then it should need but a modicum of courage to hold fast to that conviction. The medical profession is in a strong position and should be more conscious of that fact. Its services are indispensable to the welfare of the community and will, of course, never be withheld. But it can determine the conditions of its work and insist upon maintaining a framework of liberty and freedom which at the same time includes order. That framework of freedom and liberty is not present in the National Health Service Act of 1946, and the Minister has refused to modify its structure. Some medical men have argued that to oppose the Act is to oppose the will of the people as expressed through Parliament. But as Dr. Hill put it in his speech last week: "The Minister has told us of our right as individuals and our right collectively to determine our attitude to this Service. We are within our rights in saying 'No.' "

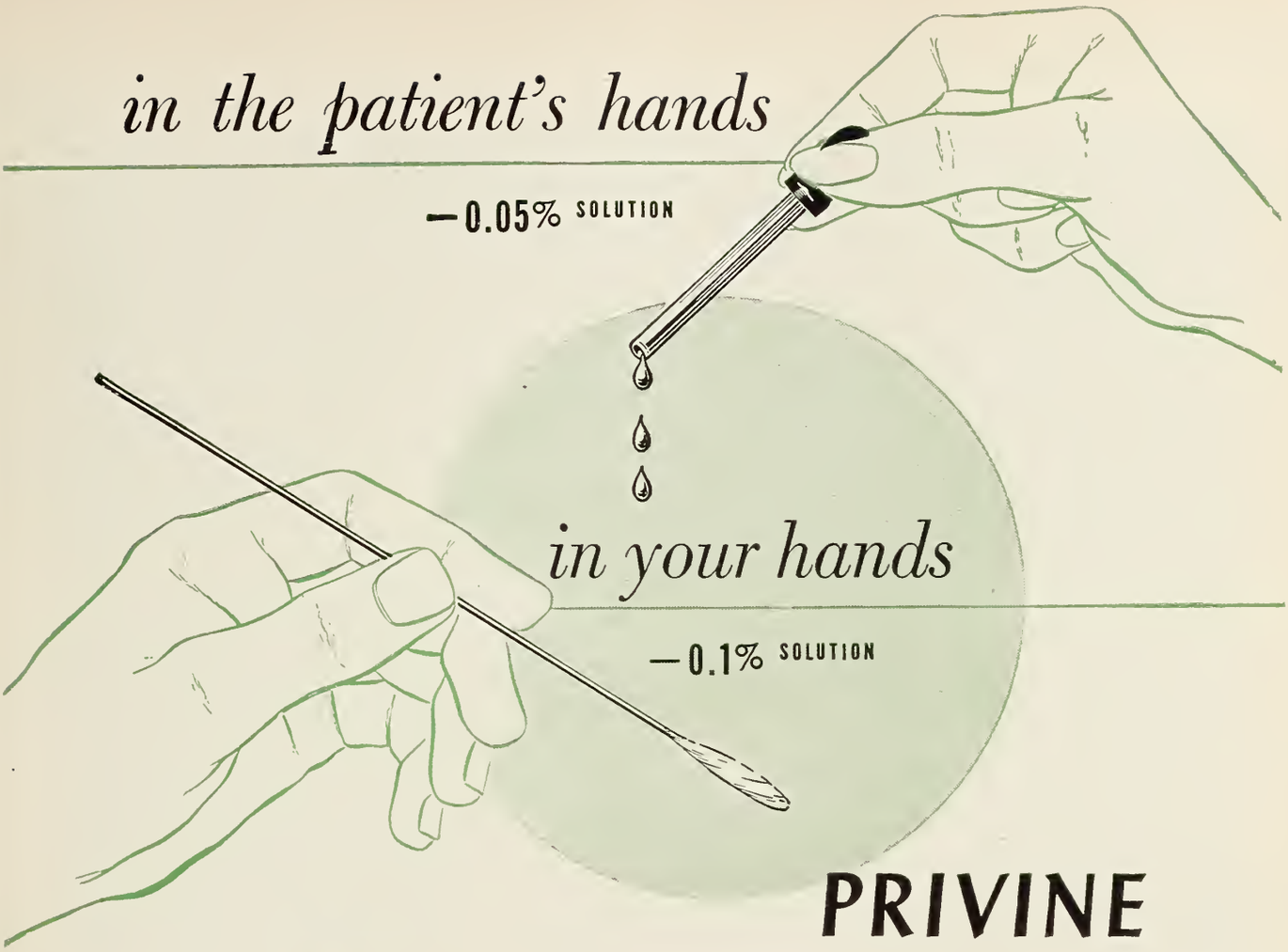
Mr. Bevan has refused the right of practitioners to appeal to the Courts against the decision of the Minister to remove him from the Public Service—a Public Service which is to include every man, woman, and child in the country. This right of appeal has been included in the Health Service Bill of Northern Ireland. This is "the new despotism"—the execution of justice by the head of an administrative department of State. He refuses to amend Section 35 in spite of the fact that no one knows exactly what it means. He calmly tells the profession that if it does not mean what he thinks it means he will, after the matter has been submitted to the Courts in the future by individual practitioners, amend it in order to make it mean what he thinks it means. This attitude borders on the irresponsible. Until this Section is amended, as in due course it will have to be, no practitioner in partnership will know how he stands if he enters the Service on the appointed day. The Minister refuses to listen to the Negotiating Committee's objection to the basic salary. It sould be clear that no objection has been raised to the use of a salary to attract men into difficult or undesirable areas or even to help the young man entering practice for the first time. During the debate on the third reading of the National Health Service Bill in the House of Lords,† the Government was defeated on the basic salary issue by an amendment proposed by Lord Llewellin that remuneration should be by capitation. The real reason for basic salary was given away by the Lord Chancellor when he said: "No one could have been, as I have been, Minister of National Insurance, without realizing that the success or failure of all our schemes depends in a very large measure on our getting satifactory certification." As we said then, the reason for the basic salary is to control certification. The reason for it is distrust of the doctor. Because some doctors have been lax in certification—and the Lord Chancellor admitted that he had only come across a few instances—all doctors are to be treated as if they were offenders. The Lord Chancellor gave another warning which it is well to take to heart: "If you had abolished this per capita payment altogether and made it a straight out-and-out salary, of course that temptation would have gone." Once the National Health Service Act in its present form is in operation the Lord Chancellor's "out-and-out salary" will be introduced to remove any temptation medical men may have to act as free and responsible individuals.

The analysis made by the Negotiating Committee and again by Dr. Hill last week shows how unsubstantial is the Minister's case for abolishing sale and purchase of practices, for the payment of a basic salary, and for the distribution of doctors through the machinery of the Local Executive Councils and the Medical Practices Committee. The Minister admits that there will be a very few areas in which there will be difficulty in providing doctors. Why, therefore, does he set up this expensive and cumbersome machinery for distributing doctors? One reason he has given for abolishing sale and purchase of practices is to secure the even distribution of medical men throughout the country. But if there are so few areas which offer difficulty why again make such expensive and sweeping proposals to deal with such a small problem? On another occasion, it should be recalled, the Minister referred to the sale and purchase of practices as "an intrinsic evil." To Mr. Bevan, no doubt, all private ownership is an intrinsic evil; we believe monopoly State ownership to be a greater evil. There is even a hint in the Minister's reply that he may regard the ownership of the doctors' house as an intrinsic evil when he makes his curious proposal that the Local Executive Council may be able to buy a house for the incoming doctor. Or this may have been another attempt by the Minister to put a favourable gloss on the finances of the medical man in the proposed Health Service. Many men, it would seem, have been misled by his statements into believing that general practitioners in the Public Service of the future will all be receiving an income of about £3,300. In fact, as Dr. Hill points out, the average gross remuneration per year for the general practitioner will be £1,816. The good general practitioner who by his efforts can today build up a successful practice will suffer financially under Mr. Bevan's proposals for remuneration. The practitioner whose practice is below the average may benefit financially under Mr. Bevan's proposals. These proposals in effect are part and parcel of the levelling-down process to which this country is being subjected by the present Government on the curiously unbiological thesis that all men are equal. One result of the National Health Service Act is already visible in the big increase in the numbers of those seeking to take special diplomas and in particular the M.R.C.P. The young medical man of today who believes that his ability may be above the average is doing all he can to avoid going into general practice under Mr. Bevan's Act. He is, therefore, trying his hardest to secure diplomas that will enable him to practice as a specialist or consultant. Although he will be as much a State servant in the Consultant Service as in the General Practice Service he does at least hope to escape the economic levelling down to which Mr. Bevan's proposals subject the general practitioner of the future.

The Representative Body is holding a special meeting whilst this JOURNAL is in the press. We believe that this meeting will offer still another proof that Mr. Bevan has failed to secure the co-operation of the majority of the medical profession in the launching of his new Service. We believe, too, that the plebiscite to be taken on Jan. 31 will show that the majority of the medical men and women of this country will refuse to take service under the Act in its present form. Mr. Bevan still has time to amend the National Health Service Act so as to secure the willing co-operation of the medical profession in making it a success. If he does not seize his chance to act in statesmanlike fashion then he will put the health

(Continued on Page 254)

**British Medical Journal*, 1946, 2, 697.



PRIVINE hydrochloride, 0.05 per cent, is sufficiently potent to produce long-lasting relief in the average case of nasal congestion in patients of all ages. It is therefore the Privine preparation of choice for regular prescription purposes.

Privine hydrochloride, 0.1 per cent, fills the need for an agent which will produce the intense vasoconstriction frequently necessary for adequate visualization and for pre- and post-operative shrinkage. It is therefore the Privine preparation of choice for direct use in the office or hospital.

When properly administered, Privine hydrochloride induces prolonged vasoconstriction with relative freedom from local or general side effects. Three drops will usually produce nasal decongestion lasting 3–6 hours. Overdosage should be avoided.

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ARE WE CONVINCED?

(Continued from Page 252)

services of this country into jeopardy, embitter the relationship between the doctor and the State, and sow among doctors themselves discords that will echo for years to come.

POLL BRITISH DOCTORS ON STATE SERVICE

Ballots being mailed to Britain's 20,500 general practitioners (G.P.'s) will determine the success or failure of the labor governments' plan for socialized medicine, scheduled ot go into effect July 5. Results of the plebiscite, sponsored by the British Medical Association (B.M.A.), are to be announced late next month. Ballots must be postmarked no later than midnight, February 14.

Medical consultants and specialists of the London area already have voted 766 to 11 to refuse service in the socialized plan. Medical staffs of five London hospitals also have voted lopsidedly against entering the service.

All of the 61,000 physicians and surgeons in Britain will vote, but it will be the attitude of 20,500 G.P.'s—those who will be most directly affected by the plan—that will determine the B.M.A.'s policy and, in effect, make or break the scheme.

Seek 17,500 Physicians

If enough physicians vote to become civil servants—the government seeks 17,500—every man, woman, and child in Britain will be offered free medical and dental care, including free hospitalization and treatment. The Laborites term it the "most sweeping social change of a century."

The B.M.A. announced that if 13,000 G.P.'s, fewer than two-thirds, vote against the scheme, the B.M.A. will advise all doctors to refuse to sign contracts with the government. Officials of the association called for a boycott of the plan on the grounds that it is the first step toward state dictatorship of the profession and that initiative and enterprise, vital in medicine, will be strangled by red tape.

Questions Submitted

All physicians will be asked to answer the statement:

I approve (or disapprove) of the national health service act in its present form.

General practitioners, consultants, and specialists not holding full-time salaried posts will mark the ballot on these statements:

I am in favor (or not in favor) of accepting service under the act in its present form.

I agree to abide by the decision of the majority and undertake not to enter the service if the answers to the question reveal a majority against undertaking the service and if so advised by the B.M.A.—or—I do not agree to abide by the decision of the majority if it is against accepting service.

Two Urge Support

Indication of how the G.P.'s may decide was given when the Marylebone branch of the B.M.A. voted 280 to 5 against participation. Only two medical groups have urged their members to support the plan—the Socialist Medical association with 1,000 members, and the Council of Medical Practitioners union representing 5,000 physicians.

Physicians who sign up with the state will be paid a basic salary of $1,200 a year plus a capitation fee of $3,032 for each list of 1,000 patients, with a limit of 4,000. They also will receive an allowance for mileage and fees for emergencies, anesthetics, special drugs, and for treating temporary residents. There is strong opposition to the method of payment.

Under the act, physicians who wish to remain outside the service may continue private practice, but they will be required to ask government permission for space in nationalized hospitals and must obtain drugs and supplies from the state.—Kermit Holt, *Chicago Tribune Press Service,* London, January 25, 1948.

* * *

THIRD ANNUAL CANCER DAY PROGRAM

The Genesee County Medical Society will present its third annual Cancer Day Program in Merliss Brown Auditorium, Hurley Hospital, Flint, Michigan, Wednesday, March 31, 1948.

Program

Forenoon Session—9:40 A.M.

Presiding—P. L. Ledwidge, M.D.
President, Michigan State Medical Society
Detroit, Michigan

Address of Welcome

Frank D. Johnson, M.D., President, Genesee County Medical Society, Flint, Michigan.

"Cancer of the Osseous System"

Charles F. Branch, M.D., formerly Professor of Pathology, Boston University Medical School, Boston Mass. Assistant Director of American College of Surgeons, Chicago, Illinois.

"Cancer of the Lung"

Richard H. Overholt, M.D., Clinical Professor of Surgery, Tufts University Medical School, Brookline, Massachusetts.

Recess

Afternoon Session—2:00 P.M.

Presiding—Norman F. Miller, M.D.
Professor of Obstetrics and Gynecology, University of Michigan Medical School,
Ann Arbor, Michigan.

"The General Principles of Cancer Management"

Allen O. Whipple, M.D., Emeritus Valentine Mott Professor of Surgery, College of Physicians and Surgeons of Columbia University, and Director of Surgery, Presbyterian Hospital. Director of Surgery, Memorial Hospital, New York City.

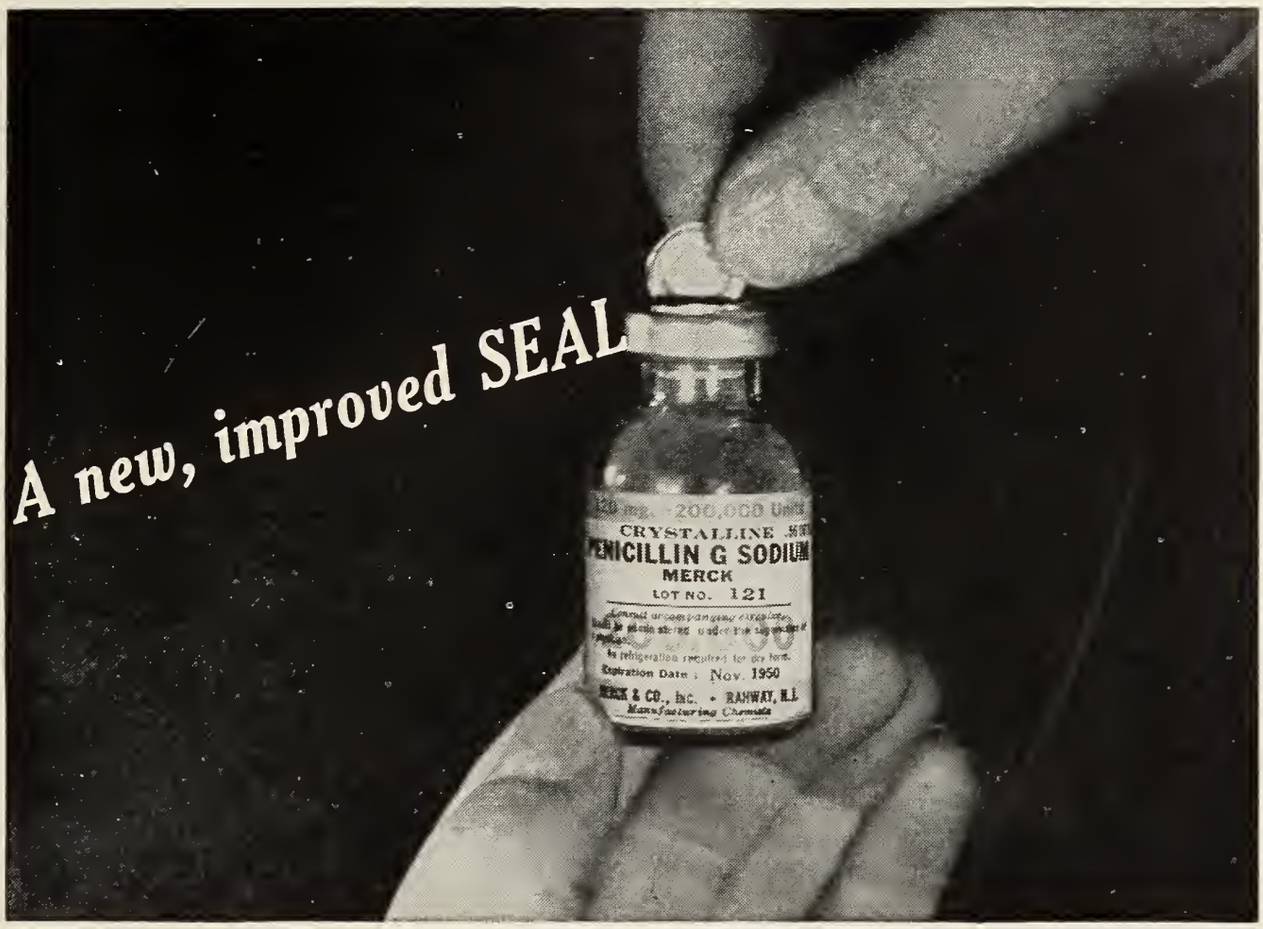
"Extensive Surgical Procedures for Cancer"

Alexander Brunschwig, M.D., formerly Professor of Surgery, University of Chicago. Attending Surgeon, Memorial Hospital, New York City.

"The Role of Radiotherapy in the Management of Cancer"

Manuel M. Garcia, M.D., Associate Professor of Radiology, Tulane University Medical School, New Orleans, Louisiana.

Cancer Education Committee
George J. Curry, M.D.
Max Burnell, M.D.
Hardie B. Elliott, M.D.



Crystalline Penicillin G Sodium Merck is now supplied in vials with a new, improved aluminum seal.

Among the advantages provided by this new seal are:

- The round tear-off tab is easily removable and eliminates the necessity of using a knife or other implement to pry up the tab.
- The tight-fitting dust cap with skirt provides protection for the rubber stopper during storage of the vial between injections.

Crystalline Penicillin G Sodium Merck is a highly purified product from which therapeutically inert materials have been virtually eliminated.

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You and Your Business

COUP FOR BLUE CROSS AND MEDICAL PLANS

Acceptance by Dr. Paul R. Hawley, ex-chief of Veterans Administration medical and hospital services, of the executive leadership of both the Blue Cross Commission and Associated Medical Care Plans represents the staunchest blow struck to date by organized medicine and hospitals for promotion of voluntary prepayment. When Hawley assumes his new duties April 1, with headquarters in Chicago, the ninety-one hospital service plans and forty-eight medical-surgical plans will have a director who has witnessed government controlled medicine in action and has seen it fail. (Dr. Paul B. Magnuson, Chicago orthopedist, was named as Hawley's successor on January 15.)

At a press conference preceding his acceptance speech Hawley said, "I have been told by so-called experts that this undertaking is too gigantic for a private, voluntary agency and that only the government is in a position to make it successful. I would have no quarrel with this point of view except that it is invariably coupled with the provision that, to make it successful, the government would have to control medical practice. Nor would I object to the government control of medicine if this would elevate the standard of medical practice in this country. But I have seen government medicine in operation in other countries and I know what government control does to medicine. I want no part of it for our people."

An incidental yet tremendously important effect of the Hawley appointment will be its reaction on Congress. The lawmakers know Hawley. They know of his professional integrity and deep sincerity of purpose to bring the best of medical and hospital care to the American people. They are cognizant of his ability in the field of medical administration. They respect his judgment. His espousal of the voluntary way will give even the most rabid of compulsory proponents cause to pause.

The marriage of Blue Cross and AMCP which, while still autonomous, will be under a single director, comes as no surprise to those who have observed a courtship that grows from similar purposes and problems. A uniform national joint contract may be the next step.

The effect of the marriage upon those Blue Cross plans which have ignored demands of organized medicine to exclude any medical service from their hospital benefits is yet to be seen. One thing is certain, however. Where a medical prepayment plan exists side by side with a hospital care plan no valid reason exists for including radiology in the hospital plan instead of in the medical plan where it belongs.

The appointment of General Hawley as joint director by Blue Cross and AMCP is an astute coup in public relations. It is unfortunate that the AMA could not have shared in the resulting good will.

When AMCP was formed by medically sponsored prepayment plans two years ago as an autonomous agency outside the AMA, many persons thought this activity could better be carried out by a commission of the AMA's Council on Medical Service. Why, they asked, shouldn't the national office of prepayment plans, which are sponsored by medical societies, be set up within the framework of the parent medical body?

To many, the failure to follow this suggestion was a mistake that is now being demonstrated. One can be fairly certain that Blue Cross will get the glory for Hawley's appointment; while the medical profession, caught with its plans down sits on the side lines.—From *American College of Radiology News Letter,* January, 1948.

ANOTHER JOB FOR HAWLEY

VA's Dr. Hawley . . . already burdened with three major government medical assignments . . . *soon to be named head man of both Blue Cross . . . and Blue Shield* . . . preliminary to merger of these two national hospital insurance organizations.

Blue Cross has 13 million members . . . Blue Shield . . . 7 million . . . and Hawley was their logical choice . . . *as ardent opponent of compulsory state medicine* . . . advocate of voluntary medical and group hospitalization movements.

Appointment will be a blow to President Truman's State of Union message appeal . . . for national medical system.—*Army Times Vet-Letter,* January 10, 1948.

GENERAL HAWLEY NAMED CHIEF EXECUTIVE OF NATIONAL BLUE CROSS-BLUE SHIELD

General Paul R. Hawley, who reorganized and developed the medical-hospital program of the Veteran's Administration under General Omar Bradley, has been named chief executive officer of the national organization of Blue Cross hospital service plans and Blue Shield medical-surgical service plans.

Hawley is credited with being the person primarily responsible for the Michigan veterans' care program, which he sponsored while serving as Acting Chief Medical Director of the Veterans Administration. First of its kind in the country, the Michigan program for "home town" care for veterans, which was initiated in February, 1946, is administered by Michigan Hospital Service and Michigan Medical Service.

General Hawley will assume his Blue Cross-Blue Shield duties on April 1, with headquarters in Chicago. He is now Special Assistant to the Administrator of Veterans Affairs, having resigned as Medical Director of the VA on December 31.

He is chairman of the Committee for Unification of

(Continued on Page 258)

1½ MILLION DOLLARS A MONTH
PAID BY BLUE CROSS FOR CARE RENDERED MICHIGAN SUBSCRIBERS

THE more than 4,200 Michigan doctors who share in the operation of Michigan Medical Service as developed by the Michigan State Medical Society, and the 145 Michigan hospitals which operate Michigan Hospital Service are proud to present this report of their stewardship of Michigan's largest public trust.

By strict adherence to principles of non-profit operation, Blue Cross has returned to its members more than $70,000,000 in services for needed medical, surgical and hospital care. From the modest average of $57,000 per month paid to doctors and hospitals in early 1940, the Blue Cross Plans today are paying one-and-one-half million dollars a month for care rendered to Michigan subscribers. This record of public service is not approached by any other program of its kind in this State.

The financial strength and actuarial soundness of the Blue Cross program is reflected in the Statement of Condition summarized below.

STATEMENT OF CONDITION

Report of Condition as of the Close of Business December 31, 1947

MICHIGAN HOSPITAL SERVICE

ASSETS

Cash in Banks and Office	$1,578,835.71
United States Treasury and Defense Bonds	3,033,204.15
Accrued Interest	14,569.55
Subscription Fees—Receivable	87,272.67
Other Assets	137,538.19
Total Assets	$4,951,420.27

LIABILITIES AND RESERVES

Reserves for payment for services rendered subscribers (Including Unreported)	$1,894,206.62
Reserve for Unearned Subscription Fees	942,917.42
Reserve for Contingencies*	2,034,815.20
Other Liabilities	79,427.03
Total Liabilities and Reserves	$4,951,420.27
Total Benefits Paid Since Inception	$47,661,828.52

*Reserve for contingencies amounts to $1.69 per subscriber.

MICHIGAN MEDICAL SERVICE

ASSETS

Cash in Banks and Office	$ 999,393.16
United States and Canadian Government Bonds	1,625,885.14
Accrued Interest	9,166.68
Subscription Fees—Receivable	33,349.61
Funds Advanced for Veterans Administration	207,366.41
Other Assets	21,636.23
Total Assets	$2,896,797.23

LIABILITIES AND RESERVES

Reserves for payments for services rendered subscribers (Including Unreported)	$ 940,726.00
Reserve for unearned Subscription Fees	433,721.80
Reserve for Contingencies*	1,509,057.72
Other Liabilities	13,291.71
Total Liabilities and Reserves	2,896,797.23
Total Benefits Paid Since Inception	$25,300,577.39

*Reserve for contingencies amounts to $1.61 per subscriber.

THE BLUE CROSS PLANS

Michigan Hospital Service — ***Michigan Medical Service***

234 State Street – Detroit 26

GENERAL HAWLEY NAMED CHIEF EXECUTIVE OF NATIONAL BLUE CROSS-BLUE SHIELD

(Continued from Page 256)

the Medical Services of the Armed Forces, is an M.D., and is known as a capable and fearless administrator.

HAWLEY WANTS "NO PART" OF GOVERNMENT CONTROL OF MEDICINE

"I have seen government medicine in operation in other countries, and I *know* what government control does to medicine. I want no part of it for our people," Doctor Hawley declared in his speech of acceptance of the position of chief executive officer of Blue Cross-Blue Shield.

At a dinner in his honor in Washington on January 10, Doctor Hawley said:

"I have accepted this position solely because it offers an exceptional opportunity to contribute to the improvement of the medical care of our people. . . .

"Recently, I was taken to task by a well-known columnist for my convictions upon this subject. He said that, in elevating the standards of medical practice in veterans' hospitals, I had myself proved the case for government medicine. But he missed the critical point —the fact that the principal reason for poor medical practice in veterans' hospitals was that it was done by a full-time, salaried staff, isolated from the rest of American medicine; and that the principal reason for the improvement of the past two years is that we brought into our veterans' hospitals, as consultants and part-time physicians, the better medical men of the country, who are engaged in private practice."

DEMAND INVESTIGATION OF SOCIAL SECURITY ADMINISTRATION

The citizenry of Michigan might appeal to Senator Ferguson to introduce a bill to investigate expenditures in the Social Security Administration. Senator Ferguson is a member of the Expenditures Committee, of which Senator Aiken is chairman. Ferguson is honest, courageous, and a skillful investigator. He already has some insight into the SSA situation. It is essential that such an investigation be made *before* there is any floor action on S. 140 and S. 712, both designed to elevate the already powerful FSA to Cabinet status. Hearings on both these bills were heard before the Expenditures Committee.

TRUMAN LAUNCHES TEN-YEAR HEALTH PLAN

President Truman ordered the Federal Security Agency to draw up a 10-year plan for making people healthier.

"Our people want good health and are willing to work to achieve it," Mr. Truman wrote Oscar R. Ewing, FSA administrator. "Notable progress has already been made."

"But I am convinced that we have scarcely scratched the surface and that, as a nation, we can make rapid progress in the immediate future."

Mr. Truman said that what he wants is a program to round out and go with the health insurance plan law he has asked Congress to pass.

The general idea is that taxes as "insurance payments" would be collected from the people. The Government would pay doctors when they treat you. Then poor people who need a doctor but don't see one because of the cost would go.

The President wrote Ewing that health is important to "our national welfare and security" and wished to "make certain that we are taking all possible steps to contribute to its improvement."—*Detroit Free Press,* Saturday, January 31, 1948.

INSTRUCTIONAL COURSE IN MEDICAL WRITING

Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association,* will give an instructional course in medical writing at the next annual meeting of the Mississippi Valley Medical Editors' Association, to be held at Springfield, Illinois, September 29 during the annual meeting of the Mississippi Valley Medical Society in that city. No registration fee will be charged to members of the Association.

The Medical Editors' Association is contemplating changes in both its constitution and name, as it is felt that the name "Editors" is entirely too restrictive, and the name Medical "Writers" or "Authors" Association would be more appropriate. While every medical editor is a medical writer, every medical writer is not a medical editor. Since the principal purpose of the Association is to improve medical writing, hundreds of physicians should be interested in the organization, as most progressive physicians write articles and are interested in any effort to improve medical literature.

All interested in knowing more about this non-profit organization, or attending the meeting next September, should communicate with the Secretary, Dr. Harold Swanberg, 209-224 W.C.U. Bldg., Quincy, Illinois.

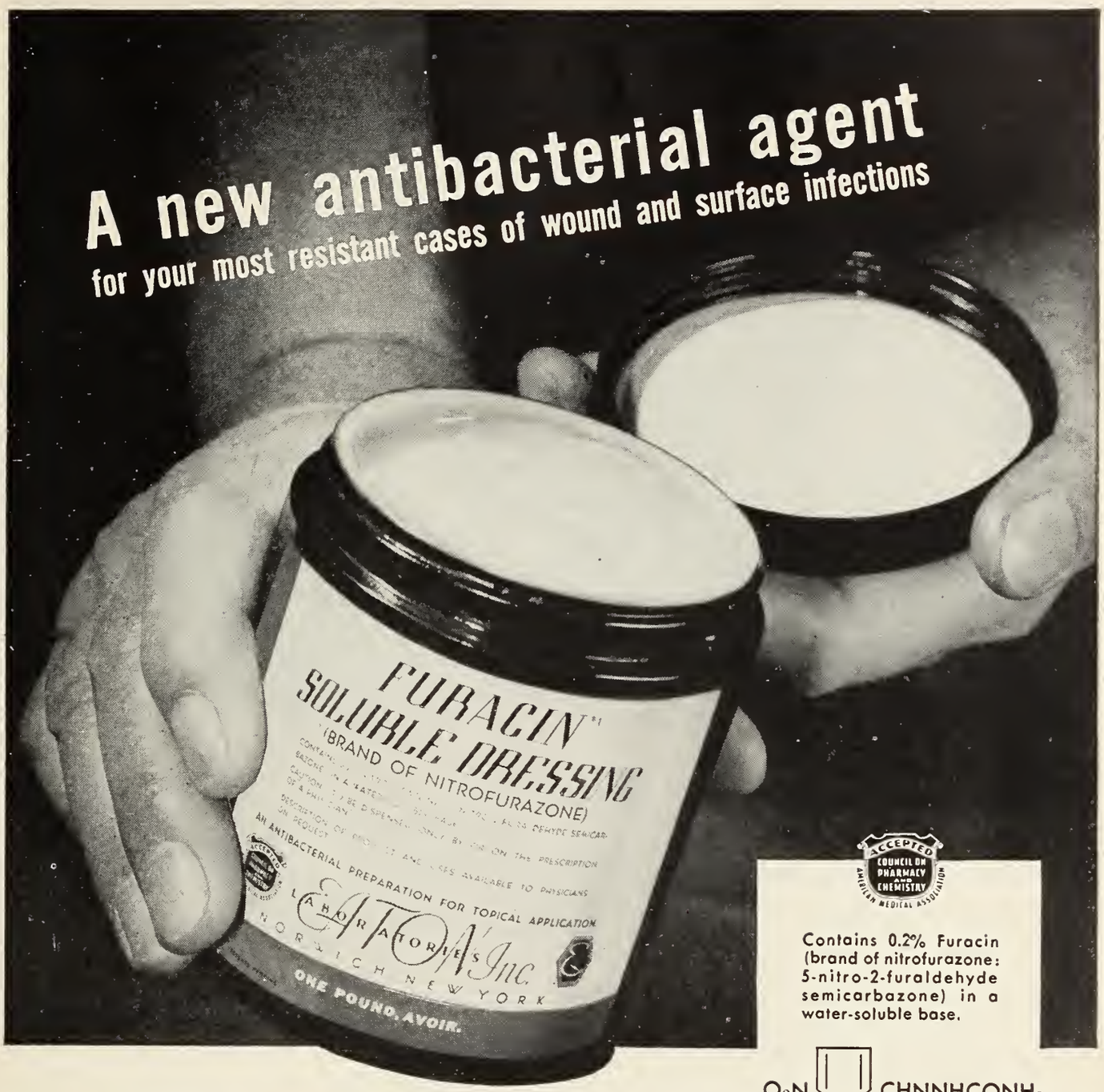
MEDICAL SCHOOLS WELL REPRESENTED IN COURSE ON ATOMIC MEDICINE AT ARMY MEDICAL CENTER

More than 20 of the country's schools of medicine have accepted invitations to send representatives to the five-day intensive course on medical aspects of atomic explosion which opens at Army Medical Center, Washington, D. C., on January 12.

Sponsored by the Armed Forces Special Weapons Project, medical services of the armed forces and the Veterans Administration, the primary purpose of the training program is to portray the various types of injury produced by atomic blast and outline fundamentals of treatment. Students are drawn chiefly from the Army, Air Force, Navy, Public Health Service, Veterans Administration and other Federal agencies.

Given once each month since last October, the course was opened in December for the first time to medical school representatives. Transmittal of invitations only a short time before the December session began resulted in the filling of only seven of these places. For January, the figure has been trebled and an even greater num-

(Continued on Page 296)



another of its several advantages:

FURACIN SOLUBLE DRESSING *has proven effective* in reducing the mixed infections of wounds and burns. Prior to treatment, Snyder et al.* found heavy growth in the majority of swab-cultures from 19 war wounds and burns. Following institution of Furacin Soluble Dressing therapy, the majority of cultures became sterile; only 4 per cent continued to show heavy growth.

Indications:

Infected surface wounds, or for the prevention of such infection
Infections of second and third degree burns
Carbuncles and abscesses after surgical intervention
Infected varicose ulcers
Infected superficial ulcers of diabetics
Impetigo of infants and adults
Treatment of skin-graft sites
Osteomyelitis associated with compound fracture
Secondary infections following dermatophytoses

EATON LABORATORIES Inc.
NORWICH, NEW YORK

*Snyder, M. L., Kiehn, C. L. & Christopherson, J. W., Mil. Surg. 97:380, 1945.

LITERATURE ON REQUEST

Editorial Opinion

BRITAIN'S SOCIALISTIC HEALTH PLAN

Great Britain's socialistic health plan offers a warning to America.

The young men who are flooding our universities with applications for admittance to the many excellent schools of medicine and dentistry should take a look at the new British health policy.

Great Britain's Socialist government is about to inaugurate a huge program of free medical care for every man, woman and child in the "tight little island."

Basically, the idea is that the government will pay everybody's doctor bills, including hospital treatment, ambulance hire, drugs and medical supplies.

The cost, as now estimated, will exceed $600 millions a year and is to be collected from the long suffering British taxpayers.

British doctors are being asked to sign up with the government's plan, although they are free to stay out if they so choose. All who do join the government medical service will receive a basic salary of $1,200 a year, to be augmented by fees of $3 per patient.

Thus, if a doctor had the time and endurance to see 4,000 patients a year, he could reach a ceiling of $13,200 before taxes.

All government doctors would have to serve in areas where the government determined they were needed most. The Health Ministry will have authority to bar doctors from locations which it considers are oversupplied with physicians.

Included in the list of services to be provided by the state are home nursing, midwives, maternity and child care clinics. The Health Ministry is also to be the final judge of a doctor's competency, thus removing the individual's rights to appeal to the courts.

* * *

Needless to say, the government's program is meeting with tremendous opposition from the British Medical Association. This group fears that eventually all doctors will be forced into state medicine with over-all salaries to be fixed by the government regardless of individual merit or background.

They cite the experience of 1912 when the doctors temporarily boycotted a national health insurance plan but ultimately had to yield. It is no secret that the British government believes it is only a question of time until all doctors must surrender to its latest experiment in socialism.

Then all medical care in the British Isles may gradually descend to the level of the least competent practitioner and a doctor with years of the best possible training and experience will find himself on the same economic level with Britain's 2,000,000 other civil servants.

We commend what is happening in Britain to the attention of America's doctors in embryo because while it is easy to say, "It can't happen here," the fact is that bills have already been introduced in the United States Congress which would take us down the same socialistic road.

You can still write your Senators and Congressmen before it is too late.—John S. Knight, *Detroit Free Press.*

WHAT THE OTHER FELLOW THINKS

The Michigan State Medical Society plans to spend $134,370.00 of the doctor's money during the next year in an attempt to clarify public opinion on health matters. This is called "Public Relations." Why has this become necessary? Or is this demand for "public relations" a theory developed to counteract government medicine?

The State of Colorado wondered about these questions and hired Raymond Rich Associates of New York to find out the answers and make recommendations. They spent $25,000 for this report. The findings might well apply to any medical society and are worth lengthy consideration.

First of all, it was found that there is a wide chasm separating medical groups from the public. The medical society, in the public mind, is isolated from the community in which it exists. Most doctors, as individuals, inspire admiration and appreciation. But the faults of a few set the tone of public criticism so that the group *collectively* does not enjoy the respect shown for individual members. It should be noted that this poll includes all income and political trends. These criticisms were not those of radicals. They represent the opinion of the general public.

The broad categories of criticism were these:

1. The cost of medical care.
2. Overcharging and the arbitrariness of setting fees.
3. Overoperating.
4. Clannishness—which protects incompetent and unethical colleagues.
5. Poor office management requiring long periods of waiting to see the doctor.
6. Too busy to discuss problems with patients.
7. A complete lack of initiative in health problems.

These criticisms, we may feel, are unjust and untrue. But right or wrong, what the other fellow thinks, we must treat with respect! His opinions are not alone based on propaganda. We can blame our own aloofness and apathy for many of the above complaints. One of our biggest mistakes of the past has been to ingore criticism we thought unjust. For years we made no attempt to supply the facts to the public on which a correct opinion could be formed.

Only recently, has the Michigan State Medical

(Continued on Page 262)



Let's Weigh the Facts About BABY QUAKER

A glance at the accompanying analysis will show that the nutritional benefits of BABY QUAKER Instant STRAINED OATMEAL deserve serious consideration. Here are the body-building, whole-grain benefits of Mother's Oats (Mother's Oats and Quaker Oats are the same)—fortified with vitamins and minerals, and especially processed for the delicate digestive systems of little babies. Its fine texture and precooking for instant preparation make it a welcome aid in baby feedings. The Quaker Oats Company invites inquiries about Baby Quaker Instant Strained Oatmeal.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

We're telling Mothers to ask you about the Mother's Oats benefits of this new baby cereal. (Mother's Oats and Quaker Oats are the same.)

TYPICAL ANALYSIS

	Per Ounce
Protein	4.7%
Fat	15.3%
Carbohydrate	6.8%
Fiber	65.1%
Minerals (ash)	1.9%
Calories	108
Calcium	216 mg.
Phaspharus	278 mg.
Iron	6.6 mg.
Thiamine	0.3 mg.
Ribaflavin	0.051 mg.
Niacin	0.41 mg.

BABY QUAKER INSTANT STRAINED OATMEAL

Public Relations Progress

The MSMS Public Relations Committee and all Public Relations media committees held interesting meetings at the Book-Cadillac Hotel, Detroit, on Saturday, January 24.

Highlights of activity reported on were:

Radio

The "Tell Me, Doctor" program is now aired daily on eighteen radio stations. Newest addition is WOAP, Owosso. This is now the largest transcription network carrying a single daily program in Michigan. A new program using FM radio is in the making.

Newspapers

The newspaper advertising program and Health News Column were renewed. Emphasis was given to publicity at the county level by a recommendation made to each County Society to appoint two members to take care of all newspaper releases on medicine in its community.

Cinema

Two committee meetings with representatives of Jam Handy Corporation (which is developing the MSMS motion picture) have set up an initial tentative outline for the picture. Immunization and Disease Control will carry the medical theme throughout.

Publications

The brochure on Medical Associates is maturing rapidly. Layout work and writing is finished, and the publishing schedule calls for distribution in April. This brochure points up the possibilities in the new field "Medical Associates" which combines all those who assist the doctor in health and medical activity—twenty-three categories in all.

Education

Two committees met to discuss health education. One set up plans for exploring educational activity in connection with schools and colleges. The other negated an idea for a Health Education Conference.

Personnel

Additional activities (Medical Associates, Rural Health Conference, Michigan Health Survey, et cetera) in the Public Relations office made necessary an assistant to the Public Relations Counsel. The Council made provision for this expansion in the 1948 budget.

WHAT THE OTHER FELLOW THINKS

(Continued from Page 260)

Society had a planned program for informing the public. This year the following media are being used: Newspapers, with health news service and paid advertising. Radio—three types of programs with state-wide coverage. Public school education through various media. Pamphlets. Cinema—films now in process of manufacture.

But public relations begins at home. Our local society has just begun to realize that we are judged by what the other fellow thinks. We cannot afford to remain aloof to the public we serve. We must let them know the facts and reasons for what we do. The newspapers are our best local medium for reaching the public. The following recommendations are from the Michigan State Public Relations Committee: Have one or two members designated to contact the press on all medical news and cooperate with the press in supplying information. Allow the press to quote doctors on health matters. Arrange an agreement with the press for coverage of medical society activity.

Some of the Rich recommendations are these: Draw up and publish a fair fee schedule for each community. Take a positive position as leaders in community health problems. Appoint a policy committee to answer complaints against individual members and let the public know it exists. "It is recognized that one erring brother will do more harm to the group's reputation than the exemplary conduct of a hundred others can readily counteract. There can be no denying that failure of the profession to regulate itself leads, through passage of corrective legislation, to greater government control."

Broader brackets of medical insurance coverage are recommended. Finally, promotion of an outstanding project is recommended. Selection should be based on the following criteria:

1. It must be fundamental and go to the roots of any problem it tackles.
2. It must lend itself to lay collaboration.
3. It must not duplicate efforts already made.
4. It must not require raising of money by doctors.
5. It must benefit the practice of medicine.
6. It must contribute to the well-being of every citizen.
7. It must have a direct appeal for the whole community.

We can well ponder these suggestions. For, what the other fellow thinks must become our responsibility for 1948.—J. E. Livesay., *Bulletin, Genesee County Medical Society.*, Dec. 30, 1947.

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 47 MARCH, 1948 NUMBER 3

Michigan's Rheumatic Fever Program

By Percy C. Angove
Detroit, Michigan

THE MICHIGAN SOCIETY for Crippled Children and Adults is very happy to have a part in the Rheumatic Fever Program sponsored by the Michigan State Medical Society. I personally consider it an honor to be a member of the State Rheumatic Fever Committee appointed by the Council of the Michigan State Medical Society.

The Michigan Society for Crippled Children and Adults is vitally concerned with any physical ailment that kills and cripples, because of the physical want and suffering occasioned thereby, seriously affecting the social and economic status of the individual, family, community, state and nation.

Our Rheumatic Fever Program in Michigan is unique in that an attempt at solving the problem is being made by the doctors of medicine. It is my understanding that there is no program like it anywhere in the United States. In fact, no other state has a state-wide, intensive program involving discovery, diagnosis, treatment and prevention.

Doctors Need Help to Do the Job

Rheumatic fever and its conditioning factors poses a very serious problem, one that calls for the help of our doctors of medicine. We realize that technically it is their job, but we also know that they cannot do the job alone—the public must be wisely informed, and in a dignified, factual manner, void of anything that might incite fear, dread and unwarranted anxiety—the doctors must be made aware of the program and the benefits to them and their patients to be derived therefrom—the parent, when it is known that a member of the family is affected with the disease, must be prepared to accept the condition and taught how to better care for their child so afflicted, following through on the doctor's instructions, even to the extent of changing home routine and environment—then there is the matter of affording prescribed therapeutic measures possibly necessitating the services of therapists—in some instances, due to home situations, nursing service will be necessary—the teachers in the schools must not only be made aware of the disease and its conditioning factors, but they must also be prepared, on an individual patient basis, to better understand the involvements and fit their particular programs to the individual needs of the child. In fact, for many patients, many aspects of community life are either directly or indirectly involved and can be made a source of much good—last, but most important, is the matter of properly educating the public and especially those who in any way have anything to do with medicine and public health, both professional and lay. In all of these considerations, the doctor must have help.

Working Together is Nothing New

The fact that we, the lay organization and the professional organization are jointly engaged in the program is fundamentally nothing new. Unobtrusively and quietly the Michigan Society for Crippled Children and Adults and the Michigan State Medical Society have been working together in the interests of better medicine and better health for many years. This is exemplified by the very close cooperative relations with respect to the

Read before the Wayne County Medical Society, January 5, 1948, by the Executive Director of the Michigan Society for Crippled Children and Disabled Adults.

projecting and safeguarding of necessary legislation, and the proper functioning of established public tax supported agencies that are organized to promote and help provide good medical service, practiced by those best prepared to diagnose, prescribe and afford proper treatment in caring for all physical ailments, for all classes of people regardless of social and economic status. For instance, there is the very splendid program administered by our Michigan Crippled Children Commission, an agency which the Michigan Society for Crippled Children and Adults helped to create, and with which public agency a very close professional relationship is maintained. Then there is our own specific program for the Cerebral Palsied, who, as a group have been neglected. It is now a proven fact that considerable can be done for these unfortunate citizens of Michigan. We, the lay organization, have initiated a program of clinical service and follow-up, and have as our consultant a nationally known medical expert in this field of medicine.

During the past year the Michigan Society has conducted six cerebral palsy clinics and five more are scheduled for this year. Such clinics are only scheduled and conducted with the approval and co-operation of local doctors of medicine. This does not mean that we are administering the practice of medicine. At the clinics already held approximately 150 children were examined and prescribed for, but, the treatment of such children is left in the hands of local doctors.

One could cite many instances to indicate that our only concern is in seeing that proper medical care is provided for those in need of it, and in this effort—the Rheumatic Fever Program—we believe that the doctors of Michigan need our help.

The Word "Cripple" is Broadly Applied

The Michigan Society for Crippled Children and Adults, organized in 1921 and incorporated under the laws of Michigan, considers the word "cripple" in its broadest sense, not only to include the visually evident or orthopedically crippled person, but also children with impaired vision, hearing, cardiacs, and other nondiscerning ills, sufficient to warrant special treatment and therapy. Truly, we recognize that "The rheumatic fever child is a crippled child."

The Michigan Society for Crippled Children and Disabled Adults is not so much concerned with the sick person involving the regular or the usual patient-doctor relationships, as with those who for reasons of poor health, legitimate or otherwise, have been neglected and pose a serious social and economic problem.

The Michigan Society for Crippled Children and Adults, which I have the honor of representing here tonight, was not at all surprised when the Michigan State Medical Society sought our assistance in furthering the Rheumatic Fever Program because the two organizations have been working together for many years and the Medical Society had already known of our broad interpretation of the word "cripple."

Program Given National Recognition

Michigan's Rheumatic Fever Program is being studied by other states. In fact, it has been given national recognition under date line October 26, it warranted an unsolicited two column spread in the *New York Times,* which article was captioned, "Michigan Program is Hailed as Curb on Rheumatic Fever. New Long Range Fight on No. 1 Child-Killer is Cited as Example for Other States." This article has been widely publicized throughout the country, the result being that other states are seeking information from us. Even though the program has been in operation a comparatively short time, it has progressed sufficiently to more than satisfy our own initial expectations, therefore we are glad to tell about the program because we realize no state borderline in work of this nature.

Disease Must be Attacked with United Effort

Rheumatic Fever, because of its serious involvements, must be attacked with co-operative effort and diligence. The serious social and economic problems involved cannot be lost sight of.

Such united effort as is in evidence in Michigan's Rheumatic Fever Program involving the lay and the professional engaged in private enterprise, is characteristic of the "American Way of Life." It demonstrates the democratic way of assuring the very best in medical practice, on an individual patient basis. May the time never come when, as regards his health, a crippled child will be considered just bolt No. 46 in the production line scheme of things. Such may apply to automobiles but not to the human soul. God forbid that the day will ever arrive when a crippled child becomes so subjected to regimentation and bureaucratic control that he will be considered "just another case."

Of course, there are and always will be a certain number of our citizens who need help in securing medical service, and there are ways and means whereby such help may be acquired, but if present services and facilities are not sufficient, then a way will be found, this too, is the "American Way."

Let us not forget for one moment that if Rheumatic Fever is to be controlled, the doctors must do the job. It is their responsibility. They only are technically trained and prepared to do it, but, if the doctors do not do this job, then there is no question in the minds of many concerned that an attempt at doing it will be made by some especially created agency, and the service administered and controlled by it. It is well to remember that the program as it operates in Michigan affords a special service to the patient through his own doctor.

Good Professional Relations Must Obtain

The Michigan Society for Crippled Children and Adults believes in the promotion of good health and good medical service furnished by those best prepared to administer it, namely the physician, but, there are agencies, public and private, that have important functions, for instance, we are very much in favor of good public Health Departments, both state and local, we like the programs of our Michigan Crippled Children Commission and Vocational Rehabilitation service, however, with all agencies and services co-operative relationships should be such that each understand and recognize their own specific purpose, prerogatives and professional limitations, to say nothing of the practice of good professional ethics.

The Michigan Society for Crippled Children and Adults is not the only private, lay organization concerned with the problem. True, our society is organized to serve the physically disabled, but other purely voluntary organizations have become interested. For instance, the National Alpha Phi Sorority has made the possibility of rendering aid in rheumatic fever projects, a prime objective, on a national scope. There are many ways in which such a voluntary organization can be of help.

I am happy to report that the State Rheumatic Fever Committee of the Michigan State Medical Society is formulating plans for utilizing the services of this sorority. Meetings have been held with representatives of the Michigan branch and the process of selecting a central steering committee, to meet as a liaison group with the State Rheumatic Fever Committee, to work out a voluntary program is already under way. The program to be integrated through the local chapters of the sorority who in turn will work through the local diagnostic centers. It is hoped that through such a plan of co-operation a wide variety of needs may be met.

Must Have Facts to Show Need

Before the society will enter into a service or project of any kind, it must have facts. With respect to Rheumatic Fever, we learned that it kills more than five times as many each year as does poliomyelitis (infantile paralysis), whooping cough, diphtheria, scarlet fever, measles, and meningitis combined; that rheumatic fever causes 40 per cent of all heart disease of all ages and 90 per cent of all heart disease in children; that during World War II battle deaths totalled 325,000, but that during the same period 2,000,000 Americans were killed by diseases of the heart! That rheumatic fever, aside from deaths, cripples more than any other disease; that rheumatic fever immobilized more than 40,000 men during World War II; that more than 200,000 men and women in the United States are invalids as a result of the disease —this does not count children who, in much larger numbers, suffer from rheumatic fever. Think of it, rheumatic fever is responsible for the loss of 152,000,000 work days each year. We assume that the above figures are authentic.

The startling facts are taken from authentic reports of an organization, which includes among other organizations, members of the American Medical Association, The American College of Surgeons, the American Academy of Pediatrics and the American Public Health Association.

We were interested in the following comparative figures especially since they are somewhat localized. On the basis of national figures, for every case of polio among children 5-15 there all 111 cases of rheumatic fever. In New York from 1942 to 1945 there were 1,281 deaths from rheumatic fever and 41 from polio, a ratio of 31 to 1. Nationally, according to insurance statistics, the ratio is 154 to 1. To carry the comparison further, the 1946 report of the Detroit Board of Health showed that deaths from polio were less than 2 per 100,000 of population, whereas deaths from rheumatic fever were 166 per 100,000. Figures from school surveys in Detroit indicate that in the age groups from 5 to 19 there are 7,400 cases among

Detroit school children right now. They are "cripples without crutches."

Good Beginning Through Private Enterprise

To date, the Michigan Society for Crippled Children and Adults, Inc., "the Easter Seal" organization, has appropriated $27,000.00 to cover the administrative expenses of the local centers, of which, outside of Wayne County, eight are now in operation and four more in the process of organization. Each center is headed by a carefully selected chairman, a doctor of medicine, who is assisted by a team of medical experts who give of their time and services free.

Up to now, approximately 1,000 suspected patients have been referred to these eight strategically located functioning centers by practicing physicians, and approximately 600 of that number have been diagnosed rheumatic fever. The clinical findings with recommendations for treatment on these cases have been returned direct to the referring physician, always the doctor-patient relationship is maintained.

Soon, to more nearly complete the state-wide program, sixteen new centers with one central administrative office will be established in Wayne County, making a total of twenty eight centers. Let us assume that if the twenty new centers function as effectively as the eight centers already in operation, that the number served will be proportionately the same for the same length of time. If so, then there should be 3,500 referrals, of which 2,100 will be diagnosed rheumatic fever. Of course, it must be remembered that the programs of the eight centers already established have been in actual operation a little over one year, because several weeks were consumed in setting up the state and local plans and procedures. We believe that phenomenal progress has been made in a comparatively short period of time, and it indicates that the physicians of Michigan, who alone have the skill to diagnose and combat rheumatic fever, are uniting to do the job.

Judging by accomplishments to date, and only a good beginning has been made, the program may be considered a success. It evidences the important fact that the doctors of Michigan are accepting the challenge to do their own job. As the need arises, more centers will be established and the ultimate goal will obtain, namely the control of the disease, through private enterprise and the free selection of physician by patient, regardless of social and economic status.

Looking Forward

We are looking forward with a great deal of anticipation to the establishment of the centers in Wayne County that will serve a large section of the population of the State. Because of working with the State Rheumatic Fever Committee of the Michigan State Medical Society, and also very closely with Dr. Norman Clarke, Chairman of the Rheumatic Fever Program in Wayne County, we know, that considerable thought and careful planning to date, will be the means of assuring the success of a very necessary and needed medical service here in Wayne County, and to the benefit of all practicing physicians and their patients in the discovery, treatment and control of the disease.

The Michigan Rheumatic Fever Program is being observed carefully and with a great deal of interest throughout the nation. We cannot fail. Working together, we will not fail. We must keep uppermost in mind, that "this disease has become a vital, burning challenge to the medical profession—the public has been aroused to its menace—many powerful voices demand that something be done about it." The Michigan Society for Crippled Children and Disabled Adults, Inc., and the doctors of Michigan have accepted the challenge. Working together we can produce the benefits to which the public is entitled.

In these very brief remarks, I have attempted to give you some idea of our philosophy which is the basis for established principles in co-operative enterprise and professional relationships in the cause of good health. I have also briefly indicated how the Michigan Society for Crippled Children and Adults entered into the joint program, its part in it, the developments to date, and hopes for the future. We are proud to have a part in what we consider a very sound and a just program. We are making an experiment, an experiment in humanity, an experiment in co-operation.

MSMS



Early and Late Ectopic Pregnancy

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HEMORRHAGE during pregnancy or labor is always pathological. A small percentage of women, it is true, menstruate for one or two months after the beginning of pregnancy, but this usually does not occur after the sixteenth week when the amniotic sac completely fills the uterine cavity. One must distinguish between menstruation and hemorrhage.

It is not intended to review completely the physiology of early pregnancy. However, for better understanding of the condition under discussion, it is necessary to consider briefly some of the changes which take place. Histologic studies on the endometrium have repeatedly brought out the fact that in the last half of the menstrual cycle a proliferative endometrium becomes secretory in character. Immediately preceding the menstrual flow, it has become thickened, compressing the tubular glands to the myometrium. This is due both to proliferation and to enlargement of the supporting cells of the stroma. Indeed, this change may be so pronounced that it is difficult to distinguish from true decidua and has been called the progestational phase of the endometrium. The formation of decidua is a very short step from the changes mentioned. When the ovum imbeds in the prepared compact superficial layer, it lies almost on the surface and is barely covered over by a few layers of cells. The burrowing of the ovum has been somewhat exaggerated. It must be emphasized that after the ovum imbeds so superficially it remains in this anatomical relationship for the entire duration of pregnancy. The fact that the developing ovum and later fetus is on a relatively insecure footing explains most of the bleeding that can occur during pregnancy, and the source is always maternal, arising from a splitting away of the spongy layer of the decidua from the wall of the uterus.

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Early Ectopic Pregnancy

The term ectopic pregnancy signifies a pregnancy in any location outside of the uterine cavity. By extra-uterine pregnancy is meant a pregnancy occuring wholly outside of the uterus. Tubal pregnancy refers to the fallopian tube, of which pregnancies there are three varieties: interstitial, isthmical, and ampullar. Ovarian pregnancy refers to the fertilization of the ovum in the graafian follicle and its subsequent development in the ovary. Abdominal pregnancy is almost always secondary to tubal or the ovarian type. Ectopic pregnancy may occur at any time during the childbearing period, but 70 per cent occur between the ages of twenty-four and thirty-three years. The causes of tubal pregnancy are varied and include mechanical interference with the passage of the fertilized ovum down the tube to the uterine cavity: either pressure on the tubal lumen from without, or obstruction of the lumen from within, and also anomalies of the tubal lumen. Pelvic inflammatory conditions, recent or remote, are probably the most frequent cause. External migration of the ovum is probably quite rare.

Pathology

The uterus is slightly enlarged and a true decidua is present. This may be cast off in small shreds between the eighth and twelfth weeks but occasionally may be extruded as a decidual cast. In the fallopian tube, a pseudo-decidua forms at the site of implantation, and as development of the ovum takes place, chorionic villi erode and invade the tubal wall. The walls of the tube are thinned and weakened, and the blood vessels eroded. There is no hyperplasia or hypertrophy of the muscle tissues. Hemorrhage results from direct erosion of the vessel wall by the trophoblast, or by rupture of the tube as a result of increased size of the ovum. The hemorrhage is usually arrested by clotting of blood. The first hemorrhage is seldom fatal. When tubal abortion takes place, the ovum escapes into the abdominal cavity from the fimbriated extremity, especially common in the ampullar variety. The ovum may escape upward into the abdominal cavity or downward into the broad ligament. Tubal abortion is the most common outcome of

tubal pregnancy in the ampulla. It usually occurs in the first two months of gestation. After tubal abortion has taken place, the ovum and a considerable amount of blood usually gravitate to the cul-de-sac and may be absorbed or form a pelvic hematocele. Abdominal pregnancy results from gradual extension of the fetal sac, either from the fimbriated extremity of the tube, or from a rupture of the tubal wall, in which case the rupture is so gradual that the placental attachment was not disturbed. Rupture of the tube gives a characteristic history. Usually while engaged in some sort of exercise the patient has a sudden sharp pain on the affected side. This is followed by a feeling of faintness and often thirst. She becomes pale, the pulse feeble and accelerated, and the respirations rapid. There may be air hunger with the body covered by cold perspiration, and the temperature becomes subnormal.

Diagnosis

Before rupture, the diagnosis is infrequently made. A history of early pregnancy and irregular bleeding makes one suspect threatened abortion or ectopic pregnancy. A tender mass located on one side of the uterus is usually present, in addition to cramp-like pain, fever, and leukocytosis. Following rupture, there is a history of early pregnancy accompanied by irregular bleeding and the occurrence of a sudden sharp pain followed by collapse. A bluish discoloration in the region of the umbilicus, according to Cullen, is helpful in diagnosis, but this sign is not constant. The differential diagnosis between abortion and ectopic pregnancy is of the greatest importance in the treatment of these conditions. Abortion occurs most frequently between the eighth and twelfth weeks of gestation, while tubal pregnancy may be encountered from the fourth to the sixth week. The bleeding in tubal pregnancy is first uterine in origin, the result of decidual separation, which usually indicates death of the ovum or fetus. The bleeding is often chocolate colored and in most instances is moderate in amount. Decidual fragments or a complete decidual cast is sometimes passed. In uterine abortion, the bleeding is frequently quite profuse and bright red in color. All bleeding is external; therefore, the amount of blood loss is a fair index of the amount of blood which the circulation has lost. In tubal gestation, the pain is generally stabbing in character and often referred to the affected side, but rarely colicky. A feeling of faintness or vomiting as a result of peritoneal irritation may be associated with the pain. Cramp-like, rhythmical pains, resembling those of labor, are characteristic of abortion.

In cases of ectopic pregnancy, and adnexal mass can often be palpated on one side of the uterus, which is semifluctuant and boggy. In the event of free bleeding in the cul-de-sac, a soft boggy mass, which is usually tender, may be palpated. The uterus will be somewhat enlarged and definitely softened. In uterine abortion, the size of the uterus will increase to correspond to the period of amenorrhea, and the adnexal region will, in most instances, be found negative to palpation. The cervical os is partially dilated. More definite diagnosis may be established by examination of the uterine contents, which would reveal chorionic villi and decidua in the case of intra-uterine gestation, but in the case of ectopic pregnancy, only decidua would be found. A frequent aid in diagnosis is puncture of the cul-de-sac or colpotomy. The Aschheim-Zondek or Friedman test is of value in arriving at a diagnosis only when it is positive. On the contrary, a negative test does not rule out the possibility of an ectopic gestation. Following the death of the ovum and the separation of chorionic tissue from the tubal wall, the hormonal test becomes negative. A positive test, however, does not eliminate the possibility of an intra-uterine gestation.

Detection of Hematin in the Peripheral Blood

A survey of the various reports in the literature concerning the diagnosis and treatment of ectopic pregnancy indicates that the results are uniformly good. Reports of success in the treatment of this condition are common, but it is rare, indeed, to find a report showing the number of operations performed when the diagnosis was in error.

In such instances, appendicitis, normal intra-uterine gestation, pelvic inflammation—with or without abscess formation—or no changes at all may be found on operation when ectopic pregnancy is expected to be found. It is evident that more accurate means of diagnosis would be helpful. To supply this need, we are trying to make more certain of the presence or absence of extravasated blood in the peritoneal cavity.

In many instances a patient is under observation because of vaginal bleeding, low abdominal pain, fever, anemia, and leukocytosis in the presence of a pelvic mass. The differential diagnosis may rest

upon the possibility of a pelvic abscess, hemorrhage into a cyst, appendicitis, intra-uterine gestation with pelvic inflammation, or ectopic pregnancy with bleeding into the abdominal cavity. It is in situations such as these that additional aids in diagnosis are of value. To identify hematin in the blood is a procedure in this direction.

The presence of hematin in the blood stream is not specific for ectopic pregnancy. Its appearance signifies bleeding into a body cavity. Hemoglobin released in a body cavity hydrolizes and liberates hematin which is absorbed into the blood. The presence of hematin suggests hemolysis from various causes. Although it gives a weak spectrum, hematin may be detected by means of the spectroscope. However, reduced hemochromogen will be formed by the addition of a reducing agent to hematin in the presence of plasma proteins. This gives a good spectrum consisting of two bands. A strong narrow band at 558 millimicrons on the spectroscope and a fainter wide band at 527 are seen. The first band at 558 is particularly characteristic.

For a detailed description of technique as used in the spectroscopic detection of hemochromogen in the peripheral blood, one is referred to a forthcoming report in the *American Journal of Obstetrics and Gynecology*. In the above-mentioned report we reviewed 100 cases in which this test was used, and, although we had four failures, there were no false positive tests. After the diagnosis of early ectopic pregnancy is established, whether ruptured or not, the treatment is always surgical. This presupposes that every effort has been made to replace blood volume before instituting surgery.

Late Ectopic Pregnancy

A few early ectopic pregnancies are undetected in the first trimester, and some of these become secondary abdominal pregnancies. In other words, they are late ectopic pregnancies. We have recently reviewed our material and find that in 13,926 deliveries there were twelve abdominal pregnancies.

The diagnosis of late ectopic or abdominal pregnancy is made on a history of an acute painful episode which corresponds to the tubal rupture or abortion prior to secondary implantation. An enlarged softened uterus, as is found in ectopic pregnancy, and a mass of varying consistency formed by the extra-uterine gestation may be revealed on pelvic examination. Hormonal tests for pregnancy are positive. The small parts of the fetus are unusually easy to palpate in the last trimester. The incidence of abnormal positions and presentations in abdominal pregnancy is increased. This is particularly true in instances of transverse presentation. In the presence of these findings, one should be suspicious of an abdominal gestation. The patient may go into pseudolabor near the expected date of delivery. Pains of increasing intensity at regularly recurring intervals may be experienced, although the reason is not evident. These pains may continue for a variable length of time. If the condition is not properly diagnosed, the pains will stop and the fetus may die.

The x-ray evidence consists of (1) the absence of a uterine shadow without the use of an opaque medium using soft tissue technique, (2) the fetus ordinarily high in the abdomen, (3) an abnormal position assumed by the fetus, particularly the transverse, and (4) the fetal parts just beneath the abdominal wall in the lateral view of the abdomen. Some advocate the injection of opaque medium into the uterine cavity, but this is not without danger.

Our twelve cases of abdominal pregnancy are summarized as follows:

Age.—The average was 29.4 years, with a variation of from nineteen to thirty-nine years.

Color.—One white and eleven colored patients were included in this group.

Gravity and Parity.—Three of the patients had not had previous children. The remaining nine had delivered five babies or less.

Months of Gestation.—Four gestations had advanced to four months. Three were five months, and there was one each at seven and at eight months. Term pregnancies numbered three. Three babies were born alive, a percentage of 27.2. Seven were previable or lithopedions. One was a full-term stillborn infant, and the other a macerated premature infant at seven months. Of the three live births, one was an eighth-month premature infant, but the other two were term.

Histories.—Histories suggestive of previous tubal abortion or rupture, i.e., pain, spotting, irregular menses, fainting, or marked weakness during early pregnancy, were given by nine of the twelve patients.

Roentgenographic Studies.—In ten of the twelve cases, x-ray pictures were taken. The films were of no value in three of the ten patients, while in one the films were interpreted as showing an intra-uterine gestation. The roentgenograms were of definite value in showing the extra-uterine pregnancy in the remaining six cases.

Presentation.—In two of the three term pregnancies and in the premature live birth, a transverse presentation was diagnosed. In the other cases no notation of presentation was made.

Preoperative Diagnosis.—The preoperative diagnosis was correctly made prior to surgery in seven of the cases. The x-ray pictures were of definite aid in diagnosis in six of these seven cases. A pneumoperitoneogram was read as showing an intra-uterine pregnancy in one case. However, all findings on physical examination pointed to an abdominal pregnancy, and at laparotomy the latter was confirmed.

Treatment of Placenta.—The placenta was removed in four of the cases. These were early gestations of four or five months where the fetus had been dead for a considerable time, and the vessels of the placentae were thrombosed and allowed for ease of separation. The placenta was removed in none of the term or near-term pregnancies. Abscesses developed in two cases. One drained spontaneously through the original skin incision and improved with no need for further surgery. The other developed a pelvic abscess which was drained through the cul-de-sac of Douglass by colpotomy. Improvement was rapid without sequelae. There was apparent absorption, with no sequelae requiring further surgery, in all other cases when the placenta was left intact.

At original operation, none of the cases were drained, nor was marsupialization done. No maternal deaths occurred in these twelve cases.

Summary

The successful management of early ectopic pregnancy is based on accurate diagnosis and, after replacing blood loss, prompt surgical treatment. We have made use of the usual signs and symptoms of early ectopic pregnancy, and the well-known aspiration from the cul-de-sac of free blood, as an aid to diagnosis. We have added the possibility of an additional aid in detecting hema-

(Continued on Page 338)

The Changing Trends in Cesarean Section

Analysis of Cesarean Sections Performed in Detroit in 1925, 1930 and 1945

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IN RECENT YEARS, increasing numbers of reports on cesarean section with mortality rates either nil or negligible have given rise to the impression that abdominal delivery may now be attended by little or no risk. To appraise this concept, a study was made of all cesarean sections performed in the City of Detroit during 1945,[2] on the assumption that a community survey would provide a more accurate over-all picture of the general status of this operation than is derived from the experiences of individual hospitals or clinics. Fortunately, two similar studies, previously made in Detroit in 1925 (Welz[4]) and 1930 (Seeley[3]), are available for comparison, thus giving the added picture of the changing trends during a score of years. This comparison is given in Table I.

TABLE I

	1925	1930	1945
Live Births	32,054	32,634	36,100
Total Births	33,416	34,007	37,028
Birth Rate	25.7	20.6	21.4
Births in Hospitals	32.2%	44.5%	94.3%
Maternal Deaths	219	215	58
Maternal Death Rate (per 1,000 live births)	6.8	6.6	1.6
Infant Death Rate (per 1,000, under one year)	80.1	64.7	33.6
Cesarean Sections	154	203	1,000
Frequency	1 in 217	1 in 167	1 in 37
Maternal deaths	20 (13%)	9 (4.4%)	8 (0.8%)
Infant deaths	17 (11%)	26 (12.8%)	78 (7.8%)

The salient features of the figures compiled in Table I are: (1) a remarkable increase in the proportion of hospital confinements during twenty years, (2) a gratifying decline in general maternal

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From Wayne University College of Medicine.

mortality, (3) an astounding increase in the frequency of cesarean section, (4) a dramatic fall in the cesarean section mortality rate, and (5) an appreciable lowering of the general infant mortality under one year, as well as that following cesarean birth.

There is justifiable pride in this record of achievement which reflects both a more enlightened obstetrical conscience on the part of the public as well as greater professional skill. There is good reason to believe that an important factor contributing to the decline in maternal deaths is the increase in hospital confinements and the fact that the majority of these (87 per cent) occurred in twenty-three maternity services meeting the standards of the American College of Surgeons. Table II summarizes the deliveries and maternal mortality rates for the thirty-nine hospitals rendering maternity service during 1945, grouping them according to size and indicating the numbers in each classification meeting American College of Surgeons requirements. It is significant to note the lower maternal mortality rates for the larger and, for the most part, more efficiently staffed and equipped hospitals.

TABLE II

Number of Deliveries in Each Hospital	Number of Hospitals	Number Approved	Total Deliveries	Maternal Deaths	Maternal Death Rate (per 1,000)
2,000 or more	5	5 (100%)	13,997	16	1.1
1,000 to 1,999	9	9 (100%)	13,130	14	1.1
Less than 1,000	25	9 (36%)	6,946	24	3.5
Home deliveries			2,027	4	2.0
Total	39	23	36,100	58	1.6

TABLE III

Number of Deliveries Each Hospital	Number of Hospitals	Number Approved	Maternal Death Rate (per 1,000)	Cesarean Sections			
				Number	Rate	Deaths	% Deaths
2,000 or more	5	5 (100%)	1.1	509	3.6%	2	0.39
1,000 to 1,999	9	9 (100%)	1.1	323	2.5%	2	0.62
Less than 1,000	25	9 (36%)	3.5	168	2.4%	4	2.38
Total	39	23	1.58	1000	2.9	8	0.80

Cesarean Sections

It is probable that the increased rate of hospital deliveries is responsible to a large extent for the decline in cesarean section mortality shown in Table I, and also for the greatly increased frequency of cesarean sections. When obstetrical emergencies arise in a hospital well-equipped for surgery, it is possible to effect abdominal delivery early and while the patient is in good condition for surgical intervention. This obviously leads to better primary results. In the less well-equipped services, sections are often performed too late or under poor auspices. Table III summarizes the cesarean section data of the thirty-nine hospitals, grouping them again according to numbers of deliveries. The superior results obtained in cesarean section mortality rates among the larger maternity services are evident from Table III. The beneficial effects of approved standards are also shown by the fact that the mortality rate for cesarean section for all the twenty-three hospitals approved by the American College of Surgeons, regardless of their size, was 0.56 per cent for 887 abdominal sections, whereas the death rate for those not approved was 2.65 per cent. In other words, 37.5 per cent of all cesarean section deaths for the entire city occurred in the sixteen small, substandard institutions where only 11.3 per cent of all cesarean sections and 13.3 per cent of all deliveries took place!

Frequency

The greatly increased frequency of cesarean section during 1945 (one in thirty-seven deliveries, or 2.77 per cent), as compared to previous years, invites critical analysis. From our compilation of comparable community cesarean section surveys published since 1937, it is evident that a greater frequency of abdominal delivery is general. The average frequency for these published reports is 2.84 per cent,[2] a figure almost identical with the Detroit incidence in 1945. The greatly increased

TABLE IV

	1925	1930	1945
Cephalo-pelvic Disproportion (including contracted pelvis and dystocia)	48 (31%)	85 (42%)	430 (43%)
Repeat Section	27 (18%)	34 (17%)	166 (17%)
Hemorrhage (Placenta previa, abruptio)	17 (11%)	25 (12%)	164 (16%)
Toxemia	26 (17%)	16 (8%)	73 (7%)
Miscellaneous	36 (23%)	43 (21%)	167 (17%)

TABLE V

Deliveries per Year	2,000 or More	1,000 to 1,999	Less than 1,000
Cephalo-pelvic Disproportion (including contracted pelvis and dystocia)	219 (43.0%)	139 (43.0%)	73 (43.4%)
Repeat Section	98 (19.2%)	63 (19.5%)	6 (3.6%)
Hemorrhage	83 (16.3%)	61 (18.8%)	21 (12.5%)
Toxemia	28 (5.5%)	25 (7.7%)	19 (11.3%)
Miscellaneous	81 (15.9%)	35 (10.8%)	49 (29.2%)
Total	509	323	168

TABLE VI

Indications for Cesarean Section	Causes of Death
Dystocia: 3	Peritonitis: 2
Pre-eclampsia: 3	Unknown: 1 Embolus: 2
Placenta previa: 1	Shock: 1 Cardiovascular pulmonary disease: 1
Abruptio placentae: 1	Exsanguination: 1

incidence in Detroit (to a point where cesarean section is now employed six times more often than in 1925) is partly explained again on the grounds that more patients are now attended in hospitals where it is possible to save mother and child by prompt section when certain types of emergencies arise. A great many obstetrical deaths in 1925 and 1930 could have been prevented by timely resort to cesarean section, and perhaps the same applies even today. On the other hand, there is reason to believe that in some quarters with exceptionally high cesarean rates sound obstetrical judgment is lacking. Among the larger maternity services of our series, with comparable cross-sections of private patients, the incidence ranged from 1.2 per cent to 7.4 per cent! It is difficult to find justification for obstetrical practice which results in one section in every thirteen deliveries, even though the mortality percentage is low. When large numbers of operations are performd on normally pregnant women without genuine complications or indications, a mortality rate results which seems surgically low, but, obstetrically speaking, is still inevitably high. The wide discrepancy of section rates in Detroit in 1945 indicates the probability that some of the lowered mortality rate was accomplished through dilution of figures with large numbers of these "elective" operations, as compared to previous years when the operation was dictated (often too late) by sheer necessity.

Indications

In order to determine further what factors may have contributed to the increasing trend toward abdominal delivery, a comparison was made of the indications given for cesarean sections performed in 1925, 1930 and 1945. This is given in Table IV which compares the major indications in each of the three periods. Table V compares the indications in 1945 according to hospitals, grouped according to size.

It is evident at once, from Table IV, that there has been a general numerical increase in cesarean sections for all causes. When viewed, proportionally, however, it appears that "cephalo-pelvic disproportion" and "hemorrhage" are growing in frequency, whereas "toxemia" now accounts for a smaller percentage of the total than in 1925.

Table V shows a surprising uniformity in the practice of the three hospital groups with respect to cesarean section for "cephalo-pelvic disproportion." The greater frequency of "repeat section" in the two larger groups of maternity services suggests that such cases drift to the hands of specialists. On the other hand, the greater proportion of sections for "hemorrhage" in the larger hospitals and the greater percentage of sections for "toxemia" and "miscellaneous causes" in the smaller ones may indicate some differences in attitude toward the management of these complications.

From the data presented in Tables IV and V it is evident that the increasing incidence of cesarean section is due to greater extension of all indications and that many operations were frankly "elective." While one cannot dispute the value of timely intervention in the presence of complications, it is equally evident from an analysis of the eight maternal deaths which occurred in 1945 that undue liberties with accepted indications and contraindications are still not permissible.

Maternal Deaths

The causes of the eight maternal deaths following cesarean section and the indications for the operations are summarized in Table VI.

Dystocia

There were two deaths among the 430 sections in which cephalo-pelvic disproportion or dystocia

ascribed to cephalo-pelvic disproportion were given as indications. In one other instance, death followed cesarean section for dystocia associated with face presentation. Although the mortality percentage for the entire group is not high (0.7 per cent), there was serious lack of evidence in many instances that abdominal delivery was completely justified.

With obvious feto-pelvic disproportion there can, of course, be no dispute. Since, however, the vast majority were frankly "borderline," this condition provided the greatest challenge to obstetrical skill and judgment. It is difficult to justify "election" of cesarean section without pelvimetry or, even better, a trial of labor, since there are no means as yet available to determine accurately the important factors of size, shape and moldability of the fetal skull, the extent of relaxation of pelvic joints or soft tissue, or the effectiveness of uterine contractions.

Case 1 illustrates, with fatal outcome, an instance in which there seems little justification for cesarean section since the clinical examination showed no evidence of disproportion and the "trial of labor" appears to have been wholly inadequate. While it must be conceded the judgment in such cases is often difficult, it is probable that competent consultation would have advised against abdominal intervention.

Case 1.—A primipara, white, aged twenty, had a normal pregnancy. Classical cesarean section was done five hours after admission to hospital in active labor with ruptured membranes. Section was indicated by "lack of progress." There was no evidence of pelvic contraction or disproportion. Infant weighed 7 pounds, and lived. There was a rising postoperative temperature despite blood transfusions, penicillin, et cetera. Death occurred on the tenth postoperative day from peritonitis, septicemia, and wound infection. Autopsy showed generalized peritonitis, necrosis of endometrium.

In contrast to ill-advised hasty resort to cesarean section in threatened or potential dystocia, undue delay in resorting to abdominal delivery when the patient has been permitted to labor to the point of exhaustion without proper regard for food and fluid requirements is even more hazardous. Under such circumstances, cesarean section may well be contraindicated since the patient has now become a poor surgical risk. In most respects, contraindications in cesarean section must be more carefully heeded than indications! The importance of more timely intervention before contraindications have developed is illustrated in Cases 2 and 3.

Case 2.—A primipara, colored, aged twenty-seven, had a normal pregnancy until term. Her hospital chart could not be found. The attending physician stated that "nausea, vomiting and exhaustion" ensued after labor of thirty-six hours. Classical cesarean section was performed under spinal anesthesia. Death occurred on the fourth postoperative day. Cause of death was unknown.

Case 3.—A primipara, white, aged twenty-nine, had a classical cesarean section twenty-four hours after rupture of membranes and prolonged labor associated with face presentation. Peritonitis and a dynamic ileus were evident before operation. Infant weighed 8½ pounds, and lived. Death occurred on fifth postoperative day from peritonitis despite intestinal intubation, penicillin, oxygen, et cetera. Cause of death was peritonitis.

While complete details are lacking in Case 2, there is reason to question seriously the advisability of classical cesarean section after thirty-six hours of exhausting labor with the patient in obviously poor condition for surgery. In Case 3, classical cesarean section (rather than cesarean-hysterectomy or, better yet, extraperitoneal section or even a vaginal operative delivery) was wrongly elected in the presence of evident infection after prolonged labor and ruptured membranes. Both cases illustrate the dangers of disregarding well-established contraindications for abdominal delivery in the presence of poor surgical condition and potential or frank infection. Chemotherapy cannot be relied upon to overcome flagrant violations of the bounds of prudence.

Toxemia

There were three deaths among seventy-three sections for toxemia, giving a surgical mortality rate of 4.1 per cent, the highest for any of the the four major groups of indications. This high mortality serves to re-emphasize the danger of routine cesarean section in eclampsia and pre-eclampsia. The importance of medical treatment in these toxemias has been demonstrated repeatedly, and in general, conservative procedures for delivery yield the best results. Nevertheless, cesarean section still has a place in the managements of toxemia under certain circumstances, notably when there is associated pelvic contraction or in the presence of certain acute complications (such as abruptio placentae). It must also be considered in progressive pre-eclampsia when no improvement results from intensive medical treatment, or where signs and symptoms of toxemia recur after therapy.

Under such circumstances, cesarean section may at times be preferable to the risks of induced labor and arduous vaginal delivery. The importance of adequate treatment as a means of reducing the surgical risk cannot be over-emphasized. Here again the challenge to obstetrical judgment is great and there is often difficulty in choosing between "too early or too late" in the interest of mother and child. The following three cases in which death followed cesarean section for pre-eclampsia illustrate these difficulties:

Case 4.— A primipara, white, aged twenty-four, was near term in her pregnancy, which was complicated by massive edema of the vulva and lower extremities, a 30-pound weight gain, hypertension and albuminuria. No improvement occurred after intensive medical treatment in the hospital for seven days. Low cervical cesarean section under spinal anesthesia was followed by immediate postoperative shock. Death occurred in one hour, forty-five minutes, despite blood transfusions, glucose, plasma, et cetera. A premature infant weighing 3 pounds 10 ounces survived. Autopsy showed marked anasarca, focal liver necrosis, hemorrhage in abdomen. Cause of death was severe fulminating pre-eclampsia.

Case 5.—A primipara, white, aged twenty-seven, had her pregnancy complicated in the seventh month by headache, dyspnea, edema, albuminuria, and mild phlebitis. There was no improvement under medical management in the hospital during three weeks. Her blood pressure rose from 154/90 to 212/140. Low cervical cesarean section was done under general anesthesia. A premature infant died in twenty-four hours of pulmonary atelectasis. There was good postoperative recovery with a fall of blood pressure to 134/100. Death occurred from pulmonary embolism on sixteenth day after operation following discharge from hospital.

Case 6.—A multipara, white, aged thirty-nine, at term in her pregnancy weighed 200 pounds. She entered the hospital with hypertension (184/120 to 200/116), albuminuria, glycosuria. The fetal heart tones were absent. Immediate classical cesarean section was done under ether anesthesia, with cyanosis and fibrillation during the operation. A stillborn fetus weighed 10 pounds 3 ounces. Death on the seventh postoperative day was ascribed to pulmonary embolus and associated "heart disease, nephritis and diabetes."

Medical treatment in Case 4 and 5 seems to have been adequate, though in the latter intervention may have been delayed unduly, perhaps in the interest of the premature fetus. In Case 6 there seems little justification for immediate cesarean section without any attempt first to improve the serious toxemia by medical treatment, especially since the fetus was already dead. It is possible that all three deaths might have resulted regardless of the method of delivery.

Hemorrhage

Of the 164 operations for antepartum bleeding, 109 were indicated by placenta previa and fifty-five by premature placental separation, with one fatal outcome in each group. While cesarean section is not justifiable routinely in all instances of antepartum hemorrhage, the excellent results obtained seem to justify the increasing use of cesarean section in these complications. The one death following section for placenta previa was definitely not due to the operation (Case 7). In the other (Case 8), poor judgment and negligent preoperative failure to replace blood loss were responsible for the outcome. These cases again emphasize the prime importance of blood replacement before any method of delivery is attempted in placenta previa and premature placental separation.

Case 7.—A multipara, white, aged thirty-two, had a classical cesarean section for placenta previa in the eighth month, complicated by severe bronchial asthma. The infant was stillborn, an anencephalic monster. Death occurred on eighth postoperative day. Autopsy showed bronchiectasis, bronchopneumonia, mitral stenosis, pericardial and pleural effusion, chronic adhesive pericarditis.

Case 8.—A multipara, colored, aged thirty-two, entered the hospital at term, with bleeding which continued for twenty-four hours and resulted in shock. Classical cesarean section was performed under general anesthesia while in shock. Death occurred at the conclusion of the operation. The uterus was filled with blood, the fetus stillborn. There had been no preoperative transfusion, but 250 c.c. of blood, 1,000 c.c. of plasma, and 500 c.c. glucose were given during the operation. Cause of death was exsanguination from premature separation of the placenta.

A cursory analysis of the eight deaths shows that poor judgment and disregard for indications and contraindications contributed to at least two of the deaths (Cases 3 and 8), and that there was questionable justification for cesarean section in two others (Cases 1 and 2). It is pertinent to observe again that three of the eight deaths occurred in substandard hospitals.

It may be significant to point out that six of the eight maternal deaths of this series followed classical cesarean section and only two after the low cervical operation. It was pointed out above that in two instances classical cesarean section was contraindicated. The superiority of low cervical

operation over the classical type seems clearly demonstrated in this series as in others. The mortality rate for 586 low cervical sections was 0.34 per cent, whereas, that for 350 classical operations was 1.71 per cent. There were no deaths among twenty-eight cesarean-hysterectomies, twelve extraperitoneal sections, or twenty-one in which the type of procedure could not be determined from the records. The increasing trend to elect the low cervical operation (58.9 per cent) is gratifying.

From the foregoing outlines of the case histories, it would appear that better judgment and more competent management might have prevented the fatal outcome (or the sections) in four of eight cases. In 1930, Seeley pointed out that three of the nine cesarean deaths of his series might have been avoided by better regard for indication and contraindications. In these respects, the situation seems unchanged. One is inclined to wonder, also, how many other errors were committed but without fatal outcome as a result of the advent of chemotherapy, antibotics and the blood bank. It must be admitted at the same time, that many urgent operations were successful as a result of these modern techniques. It is clear, however, that substantial improvements are still obtainable if indications and contraindications are better observed.

Fetal Mortality

Complete information is not available concerning the seventy-eight infant deaths which occurred in the 1,000 cesarean sections in 1945. Although the over-all infant mortality rate for Detroit in 1945 showed a substantial decline over earlier periods, the fact remains that the fetal death rate in cesarean section was more than twice the infant death rate up to the first year of life! The fact, also, that 36 per cent were known to have been stillborn is further reason for questioning in the use of cesarean sections purely for fetal indications. Acken[1] and others have discussed the problems of anesthesia, anoxia due to blood loss, and other fetal hazards in abdominal delivery. Serious efforts must be made to lower this high infant death rate in cesarean section before indications in the interest of the child can be further extended.

Conclusions

Changing trends in cesarean section are apparent from this study as well as from other reports in the current literature. The improved mortality rates seem to be related to the increasing tendency toward early and efficient treatment when emergencies arise. A further favorable trend is the fact that the majority of confinements take place in hospitals with approved standards of maternity care. The lowered maternal death rates in approved hospitals is proof of the need for further efforts to eliminate or improve all substandard institutions with their poor records.

The trend toward greater frequency of cesarean section is in accord with the general and justifiable tendency toward earlier intervention. However, there is evidence of abuse of this operation in some quarters where large numbers of unnecessary cesarean sections are performed. While a surgical mortality rate of 0.8 per cent is remarkably low, it must be remembered that it is still five times greater than the over-all maternal mortality rate. Moreover, the risk of cesarean section in subsequent pregnancies and such dangers as rupture of the uterine scar must be added to the hazards imposed by the first cesarean section. Hence, there is still no reason, either for glib statements that abdominal delivery is without danger, or for the growing tendency in some quarters to liberalize the well-accepted indications taught for cesarean section. In 1945, disregard of these indications and contraindications resulted in four of the eight maternal deaths which followed section. Had they been heeded, the death rate might conceivably have been 50 per cent lower. The dangers of cesarean section in toxemia have been repeatedly emphasized. It is gratifying to note a further trend toward less frequent use of cesarean section in toxemia, especially eclampsia. The fact that three of the eight deaths occurred in severe pre-eclamptics emphasizes the fact that toxemia is still a most serious complication.

While there has been a noteworthy reduction in fetal mortality with cesarean section, it must be pointed out again that the infant death rate is still much higher than for vaginal delivery. This fact should not be overlooked since there is a growing trend toward the election of abdominal delivery for the sake of the child.

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Comparative Morbidity in Cesarean Section

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V. J. Turcotte

THE MERE FACT that we are able to deliver a child through the vagina and have both mother and child live, does not always mean that we have practical good obstetrics. The end results of versions and major forceps deliveries often leave the mother in a semi-invalid condition or the child a spastic paraplegic. A cesarean section, while the patient is still a good operative risk, is far better treatment than insisting upon vaginal delivery at any cost. Deaths do occur after vaginal delivery, and subsequent vaginal plastic surgery is not always successful and not without mortality. It is generally agreed that cesarean section is a conservative procedure if the indications are adequate and if the operator is skilled.

During the past decade there has been a marked decrease in both maternal mortality and morbidity rates following cesarean section. This is due, in great part, to the increase in elective sections and the use of the low cervical operation. As Briscoe[2] states, "The death rate from cesarean section drops sharply as the percentage of elective operations increase. When the operation follows a period of labor, there is an increase in deaths commensurate with the duration."

According to Diekman,[4] "Watchful waiting is an essential virtue in obstetrical management, but watch out for criminal procrastination just around the corner." In the operation of choice, the membranes are intact, there have been no previous vaginal examinations, and the genital tract is potentially as free from infection as possible.

The authors have selected 100 consecutive cases taken at the transition period from routine classical section to the laparotrachelotomy during 1944 to 1946, all of which were private patients. The purpose is to show the benefits of early surgery and the superiority of the low flap operation. This is a small number of cases; yet we consider the results more accurate, for the preoperative and postoperative care and medication were essentially the same. In reports over a longer period of time, new antibiotic drugs will necessarily affect the mortality and morbidity rates.

TABLE I

Indications of Cesarean Section	Type of Operation		
	Classical	Laparotrachelotomy	Total
Previous Cesarean Section	10	14	24
Contracted Pelvis	4	24	28
Placenta Previa	10	9	19
Toxemia	3	5	8
Placenta Abruptio	2	5	7
Complete Perineal Repair	1	4	5
Transverse Presentation	1	3	4
Cephalo-Pelvic Disproportion	2	1	3
Uterine Inertia	1	—	1
Pelvic Deformity	1	—	1
Total	35	65	100

At its origin the laparotrachelotomy was reserved principally for those cases which were considered potentially infected, and the results were uniformly good. Since the laprotrachelotomy is considered better in potentially infected cases, it should work equally as well in clean cases. The only defense for the classical section is that it requiries less time, but this was not appreciable in our series. The supposed difficulty in incising and developing the bladder flap was not apparent, since this procedure required only a matter of seconds. We have found, as did Barney, Fish and Reimenschneider,[1] that maternal morbidity declined with the increased use of the low flap operation.

Our procedure followed the recommendations of Phaneuf[15] for careful prenatal study, which consisted of complete physical examination, external pelvimetry, Kahn test, Rh factor determination and chest x-ray taken at first prenatal visit. Then, during the last month of pregnancy, all primiparas had an x-ray pelvimetry. This last procedure we have found to be of great value, agreeing with Thoms[18] and Stander[71] that knowledge of the true capacity of the bony pelvis may increase the incidence of cesarean section as an operation of choice over the difficult forceps or breech extraction, but will decrease the employment of the operation when disproportion is suspected but does not actually exist on roentgen examination. Thus the

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TABLE II. MORBIDITY RATE

	Classical	Laparotrachelotomy	Total
Elective Sections	18.7%	5.8%	10%
Emergency Sections			
Not in Labor	26.6%	5.5%	15.1%
In Labor	50%	38.4%	41.1%

operation is done earlier and more frequently upon proper indications, and unnecessary section is therefore decreased.

Anesthesia.—Cyclopropane was used on all but three of these patients, in which instances a local anesthetic was employed. On reacting from anesthesia, each patient was given 1/8 grain of morphine intravenously, which effectively controlled the period of excitement usually encountered at this stage.

Maternal Mortality.—There were no maternal deaths in this series.

Maternal Morbidity.—The morbidity standard used has been that of the American Committee on Maternal Welfare. For this series the maternal morbidity rate was 17 per cent, which compares favorably with morbidity statistics of this period. It is striking to note the effect that the type of operation had on the morbidity rate of these cases. There were thirty-five classical sections, of which nine patients (25 per cent) were morbid; the remaining sixty-five cases had low cervical sections, and of these, eight patients (12 per cent) were morbid. Thus our morbidity rate in classical sections was double that in the low flap operation. We considered these results quite decisive, in that the low cervical sections herein reported were the first in our series, and our technique had not yet been perfected.

In separating these cases into emergency and elective sections, we considered patients in labor and those who had profuse hemorrhage, due to placenta previa or placenta abruptio, as emergency, and all others as elective sections. Under this classification we had fifty emergency and fifty elective sections. Of the fifty emergencies 24 per cent were morbid, while in the fifty elective sections 10 per cent were morbid. Thus the morbidity was more than double in the emergency sections.

Table II demonstrates the morbidity rates according to type of section under various conditions.

The results have convinced us of the superiority of the laparotrachelotomy over the classical section, and of the marked effect labor has on the morbidity rate. Therefore, we are making every possible attempt to recognize the indications and decide on operative delivery before labor begins. Whenever a test of labor is decided upon, it is carefully supervised in order to avoid reaching the stage of hopeful procrastination.

The postoperative convalescence has been greatly shortened by transfusion and early ambulation. We have routinely transfused each patient on the operating table; more than 500 c.c. of blood was rarely needed, as indicated by subsequent blood counts.

In the beginning we were rather skeptical about early ambulation, and finally allowed our patients upon the third postoperative day. We found that all of these patients felt very much better and were stronger than were others that remained in bed as previously. Now we allow cesarean section patients up on the first postoperative day, and find, as did Headings and Palmer,[9] that the results are still more satisfactory. Under this procedure we are able to discharge most of our patients on the seventh postoperative day, feeling fine and in better general condition than previously. There have been no ill effects as a result of early ambulation during the postnatal stage or on subsequent examinations.

Discussion

The results of this series have converted us to the use of the laparotrachelotomy as the operation of choice in cesarean section. Our morbidity rate, as demonstrated, was 24 per cent after classical section, whereas on changing to the low cervical procedure, the morbidity rate dropped to 12 per cent. In addition to this improvement, the low flap operation is considered much safer for the patient in future pregnancies. We have allowed patients to deliver vaginally following a low cervical section with no difficulty. Yet, in the past year we have had three patients with previous classical sections go into premature labor; and although this was of short duration, one had a complete rupture of the uterus, and the remaining two showed evidence of partial tearing through the old uterine scar at operation. The opinion that the increased use of the low section will result in an equal incidence of ruptured scars has not materialized.

Grusetz and Tisdall[8] were able to report only six ruptured low transverse scars in the literature.

Summary

1. The maternal mortality rate following cesarean section decreases as the number of elective sections increases. In the operation of choice, the membranes are intact, there have been no previous vaginal examinations, and the genital tract is potentially as free from infection as possible.

2. X-ray pelvimetry is a valuable aid in determining pelvic capacity and recognizing indication for section earlier.

3. In this series the maternal morbidity rate following classical section was double that following low cervical section.

4. The morbidity rate of patients in labor was almost three times that of patients not in labor. Here again, the laparotrachelotomy was superior.

5. Early ambulation and adequate blood transfusions markedly decreased convalescence, and hospitalization.

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MSMS

COURSE ON ATOMIC MEDICINE

(Continued from Page 258)

ber is expected for the February course, which will be the last in the series.

Including the trial session held last May, 430 doctors have taken the special instruction in the four courses held to date. Instructors are specialists in the various phases of radiation and blast injury from the Army, Navy, Public Health Service, Veterans Administration, Atomic Energy Commission and Armed Forces Special Weapons Project.

The course does not take up in detail the technical aspects of radioactivity. Because it is only five days in length, it is concerned only with the fundamentals of radiation hazards, diagnosis and treatment.

The Doctor in Court

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MOST PHYSICIANS are, of course, cognizant of the great responsibility they bear in their professional capacity and in their relationships with not only their patients but the public and community as well. One of the greatest services they render is in aiding the attorneys and courts of law to establish the truth in litigation and pretrial investigation. Their exposure of the would-be deceiver by incontrovertible scientific proof, in the form of objective tests or experiments and medical testimony, is one of the strongest bulwarks against a miscarriage of justice. On the positive side, their testimony and scientific proof in support of the bona fide claimant who has suffered a grievous injury or who has been unjustly accused of wrong doing is often responsible for the true administration of justice.

Prompted in no small degree by the war, rapid developments in the various specialized fields of medicine and biochemistry have perfected to the degree of proven scientific accuracy various chemical tests or analyses and medical experiments. The chemical analyses of body fluids to determine nonpaternity, intoxication, and disease, and the use of truth serums, lie detectors, and other scientific apparatus to detect the would-be deceiver, have been of invaluable assistance to the law in establishing the always sought-after truth.

Before the results of scientific experiments may be admitted in evidence in the courts, the law demands proof of their accuracy. Just as the careful practitioner of medicine waits until time and scientific tests, together with checked and controlled results, establish the accuracy of the particular treatment or experiment, the law requires scientific proof that these tests are accurate and foolproof before the results will be considered as evidence of the facts they purport to establish.

Presented at the Pathological Section of the Michigan State Medical Society at the eighty-second annual session, September 25, 1947, Grand Rapids, Michigan.

Blood Grouping

Medical authorities now generally recognize the efficacy of the blood grouping or serological tests to prove nonpaternity.[1] As a layman, I am not entering into a detailed analysis of the medical principles involved, especially to such a distinguished group of authorities on the subject. However, a brief explanation in the layman's language of the basic concepts might be helpful in pointing out a few of the legal aspects.

Hereditary characteristics are established by units known as genes, which occur in pairs in rod-like chromosomes of the cell nuclei. The four human blood groups are pre-determined by the presence or absence in the chromosomes of two genes, called A and B. Of the people, 42 per cent have only A, 10 per cent have only B, 3 per cent have both A and B, and 45 per cent have neither A nor B and are designated as type O.

There are ten different blood combinations of parents, and we are told a child cannot have a gene which is not present in at least one of his parents. Consequently, if a gene is found in the child's blood which is not present in either the known mother or the alleged father, the alleged father must be eliminated as a possible parent. For example, if the known child belongs to group B and the known mother to group A, an alleged father who also belongs to group A is eliminated. It is estimated that at least one-third of the false accusations of paternity can be detected in this manner.[2]

However, if the known mother and alleged father are A and B, respectively or conversely, they are capable of producing a child of any one of the four types, and the putative father cannot be eliminated. Of course, even if a child and alleged father are found to have the same gene, the test cannot establish that particular individual, who is only one of millions in the same group, as the actual father of the child.

Because of this lack of probative value and the likelihood of the jury to attach too much significance to the findings, inconclusive results of the serological tests will not be admitted in evidence in a court of law.[3] But where the test establishes the impossibility of parenthood, the evidence is admitted[4] and is generally determinative of the issue.[5]

If any one of the three participants object to the test, there are serious legal barriers confronted. In some states, statutes have been enacted, authorizing the court to order the serological test in certain types of civil cases.[6] In those jurisdictions where no statutory authority exists, there is an unsettled legal question as to whether the courts have inherent power to order the test.[7] Even in those states possessing statutory authority, the law has been restricted and narrowly construed by the courts.[8] For example, in a New York will contest there was a question of fact presented as to whether the testator's daughter, a legatee under the will, had an illegitimate child. The legatee's husband, who was not a party to the litigation, refused to submit himself to the test. The court held that, as the statute authorized the taking of blood samples only from the litigating parties and their children, the husband who was not a litigant, could not be compelled to submit to the test.[9]

Serologic Tests

In criminal and quasi-criminal cases, the compulsory taking of blood samples for the serological test may be held to be in violation of the citizen's privilege against self-incrimination embodied in and protected by the Constitution of the United States and the various state constitutions.[10] Although there is a division of legal authority, several courts have held the self-incrimination privi-

1. Muehlberger and Inbau: "The scientific and legal application of blood-grouping tests," 27 J. Crim. L. 578 (1937). Britt: "Blood-grouping tests and the law," 21 Minn. L. Rev. 671 (1937). Gatton: "Blood-grouping tests and their relationship to the law," 17 Or. L. Rev. 177 (1938).

2. *Journal of American Medical Association,* 104:2002, (June 1) 1935.

3. Flippen vs. Meinhold, 156 Misc. 451, 282 N.Y.S. 444 (1935), where the court denied the petition of the mother for the serological test because the results thereof could only be introduced in evidence if unfavorable to her claim and indicating nonpaternity. People ex rel. Downey vs. Davis, (Unreported) Domestic Relations Court of Chicago, 22 Min. L. Rev. 836 at 841 (1938); 163 ALR 939.

4. State vs. Damm, 64 (S.D.) 309, 266 N.W. 667 (1936); State ex rel. Slovak vs. Holad, 63 Ohio App. 16, 24 N.E. (2d) 962 (1939); Beach vs. Beach, 72 App. D. C. 318, 114 F. (2d) 479, (1940); Brady vs. Cacciottoli, 258 App. Div. 826, 15 N.Y.S. (2d) 177 (1939); State vs. Cyark, 144 Ohio St. 305, 58 N.E. (2d) 773 (1944); Baker vs. Weiss, (Pa.), 52 Dauph Co. Rep. 50 (1941); Euclid vs. State, 231 Wis. 616, 286 N.W. 3 (1939).

5. State vs. Wright, 59 Ohio App. 191, 17 N.E. (2d) 428 (1938), where the Appellate Court reversed a conviction of bastardy as against the great weight of the evidence and ordered a new trial when serological test divulged defendant could not be the father. To the same effect see Commonwealth vs. Visocki, 23 Pa. D. & C. R. 103, (1935); and Euclid vs. State, 231 Wis. 616, 286 N.W. 3 (1939).

In Spencer vs. Spencer, 53 Dauph Co. Ct. (Pa.) 241 (1942), test result indicating nonparentage was held conclusive of the issue.

But to the contrary see Arais vs. Kalensnikoff, 10 Cal. (2d) 428, father even though test indicated impossibility of parenthood.

6. New Jersey (N.J.S.A., 2:99-4, Sec. 2, Chapter 221 of the Laws of 1939). New York (Sec. 306-a of the Civil Practice Act). Ohio (Ohio General Code, Sec. 12, 122-2. Wisconsin (Sec. 166. 105 Wis. Stat.).

7. To the effect that courts possess such inherent power see State vs. Damm, 64 (S.D.) 309, 266 N.W. 667 (1936); State ex rel. Van Camp vs. Welling, 22 Ohio L. Abs. 448; Arais vs. Kalensnikoff, 10 Cal. (2d) 428, 74 P. (2d) 1043, 115 A.L.R. 163 (1937).

But to the contrary see Taylor vs. Diamond, 269 N.Y.S. 799, 241 App. Div. 702 (1934); Commonwealth vs. English, 123 Pa. Super. Ct. 161, 186 A. 298 (1936).

8. Bednarik vs. Bednarik, 18 N.J. Miss. R. 633, 16 A. (2d) 80 (1940); State vs. Mercer, 34 Ohio L. Abs. 362, 21 Ohio Ops. 317, 6 Ohio Supp. 303 (1941); People vs. Karlan, 13 N.Y.S. (2d) 482 (1939).

9. In re Swahn, 158 Misc. 17, 285 N.Y.S. 234 (1936).

10. Fifth Amendment to the United States Constitution reads in part as follows: " . . . nor shall he be compelled in any criminal case to be a witness against himself . . ."

Art. 2, Sec. 16 of the Michigan Constitution reads in part as follows: "No person shall be compelled in any criminal case to be a witness against himself . . ."

See 8 Wigmore, Evidence, 3rd ed., Sec. 2252.

lege extends beyond utterances of mouth to include real evidence extracted from the accused such as physical examinations of the person, bodily fluid samples, et cetera.[11] In those jurisdictions which hold that the privilege encompasses all evidence, blood samples for the serological test taken without the consent of the individual and indicating his perpetration of a crime would be ruled unconstitutional and results of the test not admitted in evidence. The modern trend of the legal authorities, however, limits the privilege to utterances,[12] and in those jurisdictions results of the serological tests would be admitted in evidence even where the blood samples were taken from the parties without their consent. At least one court has also held that compelling submission to the serological test violates the constitutional privilege against unlawful search and seizure of the person.[13] Still another court has considered the test too dangerous to health to permit compulsory use.[14]

The serological test has been of great assistance in detecting the illegitimate child born in wedlock. A very strong, almost conclusive presumption of law arises as to the legitimacy of a child conceived or born to a married mother.[15] The husband is presumed in law to have access to his wife.[16] Even if the wife's adultery during the period of conception is proven, the law will not weigh the probabilities of the paternity if the husband cannot establish his incompetency or lack of access during that part of the gestation period in which it is scientifically possible for the baby to have been conceived.[17]

This very strong presumption of law is held rebutted by a serological test which establishes that the husband could not be the father of his wife's child.[18] Thus, where the mother consents that herself and baby be tested and the results show nonpaternity, the problem of establishing the illegitimacy of the child is greatly simplified. If the mother refuses, the husband has the often insurmountable task of establishing his complete lack of access during the gestation period. This task is made doubly difficult by the incompetency of the husband to testify as to lack of access under the old rule of law, still in force in most states, that neither husband nor wife may testify as to any facts tending to bastardize children born or conceived during their union.[19] You can well imagine that finding evidence as to the occurrence or nonoccurrence of sexual intercourse between a husband and wife, outside of the two participants concerned, is, to say the least, most difficult.

We established this lack of access in a recent case by the husband's service discharge papers which contained exact dates of his sailings to and from overseas duty. This veteran who had married in 1941 returned from an eighteen-month period overseas to learn his wife had been her employer's mistress during his absence. He had intercourse with his wife for the first time in nearly two years on May 11, 1945, not knowing at that time of her infidelity. Exactly 220 days thereafter, on December 17, 1945, his wife gave birth to a mongolian idiot, 21½ inches long and weighing 7 pounds, 3½ ounces. The lack of access of the husband before 220 days prior to the child's birth was clearly established, but the wife asserted the child was born prematurely and actually conceived when she met her husband on May 11.

On May 29 the wife's physician made a vaginal examination, diagnosed pregnancy, and predicted the child's birth on December 21, or within four days of the actual birth. The hospital records in-

11. From 16 Corp. Juris 566, Crim. Law. Sec. 1097:
"Some authorities limit the protection to a prohibition against compulsory testimonial self crimination, while others hold that the constitutional guaranty protects one from being compelled to furnish evidence against himself, either in the form of oral confessions or of incriminating admissions of an involuntary character or of doing an act against his will, which is incriminating in its nature."
See also 14 Amer. Juris. 879, Crim. Law. Sec. 160.
State vs. Height, 117 Iowa 650, 91 N.Y. 935 (1902) blood test to determine venereal disease; People vs. Corder, 244 Mich. 274, 221 N.W. 309 (1928) physical examination; Apodaca vs. State (Tex. Crim.), 146 S.W. (2d) 381 (1940) physical examination.

12. From People vs. Placido, 310 Mich. 404, 408, 17 N.W. (2d) 230 (1945):
"The more modern view is that privilege against self incrimination applies only to prevent testimonial compulsion."
See also State vs. Graham, 116 La. 779, 41 So. 90 (1906) measurement of feet; State vs. Cram, (re) 160 P. (2d) 283 (1945) blood sample to determine intoxication; McFarland vs. U. S., 150 F. (2d) 593 (C.C.A. D.C. 1945) physical examination; State vs. Skidmore, (Nev.) 92 P. (2d) 979 (1939) physical examination; Green Lake County vs. Domes (Wis.) 18 N.W. (2d) 348 (1945) physical examination; State ex. rel. Van Camp vs. Welling, 22 Ohio L. Abs. 448, 6 Ohio Ops. 371 (1936) serological test; State vs. Damm, 64 S.D. 309; 266 N.W. 667 (1936) serological test; Shanks vs. State (Md.), 45 A. (2d) 85 (1945) blood grouping test; Ash vs. State, 139 Tex. Crim. R. 420, 141 S.W. (2d) 341 (1940) where fluoroscope was used to detect stolen rings and enema employed to extract from accused's body; People vs. Automobile (Cal.) 168 P. (2d) 443 (1946) where stomach pump was used to extract marihuana cigarets swallowed by the accused.

13. Bednarik vs. Bednarik, 18 N. J. Misc. 633, 16 A. (2d) 80 (1940).

14. Com. vs. English, 123 Pa. Super. 161, 186 Atl. 298 (1936).

15. 7 Amer. Juris. 636 Bast. sec. 14.
See also Yanoff vs. Yanoff, 237 Mich. 383, 211 N. W. 735 (1927); Westfall vs. Westfall, 109 Ore. 224, 197 Pac. 271 (1921); Wallace vs. Wallace, 137 Iowa 37, 114 N.W. 527 (1908); Ewell vs. Ewell, 163 N.C. 233, 79 S.E. 509 (1913).

16. Jacobs vs. Jacobs, 146 Ark. 45, 225 S.W. 22 (1920); State vs. Shaw, 89 Vt. 121, 94 Atl. 434 (1915).

17. From 7 Amer. Juris. 637 Bast. sec. 15:
"Ordinarily, if a husband had access to his wife so that by the laws of nature he could be the father of a child born in wedlock, it must be presumed to be his, and access between husband and wife is presumed until the contrary is plainly proved. And in cases where only usual or normal periods of gestation are involved, there will be no guessing or weighing of probabilities as to the fatherhood of a child where the husband and another person both had access to the mother during such period."

18. Schulz vs. Schulz, 35 N.Y.S. (2d) 218 (1942); Com. vs. Visocki, 23 Pa. D. & C. 103; State ex rel. Walker vs. Clark, 144 Ohio St. 305, 58 N.E. (2d) 773 (1924).
But see Baxter vs. Baxter, 283 N.Y.S. 657 (1936, unreported in permanent volume but discussed in 23 A.B.A.J. 472, 474) where Domestic Relations Court of New York held presumption of legitimacy precluded introduction into evidence results of serological test indicating nonpaternity husband.

19. Jones, Evidence sec. 96; 7 Amer. Juris. 641-2 Bast. sec. 21.

troduced in evidence and the physician's testimony also established that her last menstruation period had begun on March 15 and that her usual menstrual cycle was twenty-eight days.

We called as an expert witness an obstetrician and specialist in the field of gynecology who testified that a vaginal examination could not diagnose pregnancy for at least two months after conception, that the normal gestation period runs from 273 to 280 days, but that cases have been reported running as low as 240 days and as high as 330 days, explained by some medical authorities upon the unusual menstrual cycle of the mother. He testified further that an eight lunar months child does not weigh over 5½ pounds and is not more than 16 inches in length. The specialist expressed his opinion that the child could not have been conceived only 220 days before birth under the medical history presented, especially in view of the size of the baby. In answer to the inquiry of the wife's attorney as to whether pregnancy could not actually be diagnosed within eighteen days from conception, as claimed by the mother in her case, the physician pointed out that by laboratory analysis, known as the Friedmann test, pregnancy could be determined within such a period. But he reiterated that pelvic examination, as was made in this mother's case, could not so determine pregnancy until the passage of at least the second month. On the basis of this medical testimony, the young man was granted a divorce, the child declared illegitimate, and the abortive attempt of this scheming wife to saddle her deceived husband with the care and support of a subnormal child, begotten by another man in adultery, thwarted.

Hospital Records

We have just mentioned the use of hospital records as evidence of medical facts contained therein. Often, they contain much needed information, such as the size of the child and the dates of the mother's menstruation, as in the preceding case. They are many times the only reliable and available source of evidence. Some courts have held these records inadmissible, as hearsay evidence, since the hospital clerk making the entries had no personal knowledge of the facts jotted down and thus was incompetent in law to testify under oath as to their truth.[20] But many jurisdictions, including Michigan,[21] have authorized their admission in evidence as an "act, transaction, occurrence, or event made in the regular course of business"—a recognized exception to the hearsay rule—on the grounds of necessity and trustworthiness.[22]

Hospital records are often the only available source of medical facts to the courts of law because of the physician-patient privilege rule of evidence, which prohibits a physician from testifying as to information obtained by him in the treatment of a patient.[23] This rule, which exists in at least twenty-nine of our states, including Michigan,[24] extends both to physical observations made by and disclosures made to physicians.[25] Since the purpose of the physician-patient privilege is to encourage the disclosure of all facts, thus permitting complete medical treatment,[26] the rule does not apply where no medical treatment is administered or contemplated.[27] Thus, the physician-patient rule would not seem to interfere with the serological test, as the physician or pathologist taking the blood sample is not treating the subject for a physiological disorder but is only making a blood analysis for a completely disconnected purpose. Of course, if a hemorrhage, infection, or some other condition develops necessitating medical attention, the physician-patient rule would then be applicable.

In many states, including Michigan,[27] the rule is further restricted to include as privileged only that information strictly necessary for the medical treatment. For example, in a comparatively recent case,[28] a physician called to the scene of an automobile accident to administer first-aid treatment was permitted to testify, in a civil damage action which followed, that he noticed the smell of alcohol on the driver's breath, the court holding that such information was not necessary for successful medical treatment.

20. Consolidated Coach Corp. vs. Gorman, 233 Ky. 464, 26 S.W. (2d) 20 (1930); Mutual Benefit Health & Acc. Assn. vs. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934).

21. Yager vs. Yager, 313 Mich. 300, 21 N.W. (2d) 138 (1946).

22. See statutes and cases cited in 43 Mich. Law Rev. 411. See also Clinton vs. Metropolitan Life, 96 Utah 331, 85 P. (2d) 819 (1939); Schmidt vs. Riesmenschneider, 196 Minn. 612, 265 N.W. 816 (1936).

23. 20 Amer. Juris. 528, Evid. sec. 624.

24. 36 Mich. Law Rev. 649.
The Michigan statute (M.S.A. 27.911) in regard to the physician-patient privilege is as follows:
"No person duly authorized to practice medicine or surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon . . ."

25. Rose vs. Supreme Court, et al, 126 Mich. 577, 85 N.W. 1073 (1901); Smart vs. Kansas City, 208 Mo. 163, 105 S.W. 709 (1907); Battis vs. Chicago, R. I. & P. Ry. Co., 124 Iowa 623, 100 N.W. 543 (1904).

26. People vs. Glover, 71 Mich. 303, 38 N.W. 874 (1888); Garcia vs. State, 35 Ariz. 35, 274 Pac. 166 (1929); Chicago, I. & L. R.R. vs. Gorman, 47 Ind. App. 432, 94 N.E. 730 (1911); Clark vs. State, 8 Kan. App. 792, 41 Pac. 814 (1899); Cherpeski vs. Great Northern Ry., 128 Minn. 360, 150 N.W. 1091 (1915); People vs. Sliney, 137 N.Y. 570, 33 N.E. 150 (1893).

27. 36 Mich. Law Rev. 649, and see Michigan statute quoted in footnote 24.

28. Perry v. Hannagan, 257 Mich. 120, 241 N.W. 232 (1932).

Nor does the rule apply to utterances or observations made before or after the actual professional relationship exists.[29] The privilege is also held in law to have been waived where the disclosure is made in the presence of a third party who is not assisting the doctor.[30] Of course, where the patient consents to the physician testifying, as when such testimony is given in support of the patient's own lawsuit, the rule of privilege has no application.[31]

Chemical Tests

In recent years, the pathologist has been called into court to testify as to the results of chemical analyses of body fluids to determine intoxication. By chemical analysis of the urine, blood, saliva, spinal fluid, or breath, the amount of alcohol in the system of one who has imbibed may be ascertained at any given time. Scientific tests with checked and controlled results have now established that where a body fluid contains at least 0.15 per cent alcohol to 150 mg. tested, the subject is clearly under the influence of liquor.[32] At least four states now have statutes declaring such alcoholic content to be prima facie proof of drunkenness.[33]

The American Medical Association's committee on problems of motor vehicle accidents has made the following statement in regard to chemical tests:[34]

"Since it is impossible to diagnose drunkenness adequately—drunkenness from symptoms alone—it is important that the chemical observation of the blood, urine, saliva, and breath for alcohol be used to confirm obvious intoxication. The committee of the driver of the National Safety Council has agreed that 0.15 per cent (150 mg. per cent) of alchohol by weight in the body fluids is associated with mental and/or physical inferiority and that this figure is therefore valuable in legal cases. It must be understood, however, that much lower levels of alcohol are associated with definite impairment of judgment and particularly of self criticism."

The law has recognized the scientific accuracy of these chemical tests, and their results are generally held admissible in evidence so far as their competency is concerned.[35] However, their admission in evidence rests largely within the discretion of the trial court which may exclude such testimony on any one of several grounds, viz.:

1. If the sample were taken at too remote a time from the allerged intoxication period.
2. If the physical condition of the accused or some other irregularity would not be reflected in the analysis.
3. If the specimens were not properly identified.

There are other legal barriers to the use of these chemical tests in the courts. For example, where the test is to be used in a criminal case, consent of the accused to the taking of a specimen must be secured in some jurisdictions or the constitutional privileges against self-incrimination or unlawful search and seizure will be held to have been violated and the results of the analysis excluded. Furthermore, if the analysis is performed by a physician who has also rendered medical treatment to the subject, the physician-patient privilege may become involved. For those who are interested in a more complete discussion of the legal aspects involved in the use of these chemical tests, reference is made to the speaker's article in 25 Mich. Bar. J. 169, April, 1946, entitled "Legal Limitations Upon the Use of Chemical Analyses to Determine Intoxication."

It will suffice to say here that these chemical tests, the scientific accuracy of which is firmly established, will serve a very useful purpose in medical jurisprudence. A recent Michigan case,[36] involving a medical malpractice action against a general practitioner, illustrates clearly the necessity for certainty in the diagnosis of intoxication

29. Herries v. Waterloo, 186 Iowa 538, 173 N.W. 252 (1919); People v. Koerner, 154 N.Y. 355, 48 N.E. 730 (1897); State v. Wade, 197 N.C. 571, 150 S.E. 32 (1929); Strafford v. Northern Pacific Ry., 95 Wash. 450, 164 P. 71 (1917).

30. See 36 Mich. Law Rev. 641; 28 R.C.L., Evidence, Sec. 135 P. 546.

31. 70 Corp. Juris, 439, 440, Evidence, Sec. 588.

32. "The Medical-Legal Aspects of the Blood Test to Determine Intoxication," 24 Iowa Law Rev. 191.

33. Indiana, Maine, New York, Oregon.

34. Report of Committee on Problems of Motor Vehicle Accidents of the American Medical Association, J.A.M.A., 108:2137, 1937.

35. From 20 Amer. Juris. Supp. 43-44, Evid. sec. 876:
"Physicians, in determining whether or not a person is under the influence of intoxicants, make use of a variety of tests of a more or less technical nature, the value of which appears to be well recognized in the medical profession. Where the prosecution seeks to establish the intoxication of an accused in a criminal case, evidence as to the taking of a specimen of a bodily fluid of the accused, of the alcoholic content of such specimen as determined by analysis, and expert opinion evidence as to intoxication based upon the presence of such alcohol in the accused's system, is admissible against the accused, if he voluntarily furnished the specimen of his blood, or urine or other bodily fluid, or submitted without objection to the taking of such specimen, provided of course that the identity of the specimen analyzed and the accuracy of the analysis are properly established. And it has been held in a civil case that proof of the alcoholic content of a sample of blood taken from a person whose intoxication at the time is in question is admissible in evidence, notwithstanding the existence of differences among individuals in the toleration of alcohol."
From 24 Iowa Law Rev. 191, 212:
"There can be little doubt today that the blood and urine tests have reached sufficient standardization to entitle them to admission in evidence as reliable proof."
See also Kuroske vs. Aena Life Ins. Co., 234 Wis. 394, 291 N.W. 384 (1940).

36. Johnson vs. Borland, 317 Mich. 225 (1947).

and stimulates one's interest in the adoption of such methods as chemical analyses to achieve such certainty. In that case the plaintiff's husband was arrested for drunkenness when found alongside his automobile on a road just outside Pontiac. Neighbors who knew plaintiff's husband to be a sober man urged the arresting officers to call a physician, asserting him to be critically ill. Despite the fact that a relaxed tongue, spasms, and constant groaning gave every indication of a critical illness, he was lodged in the county jail and his condition diagnosed as drunkenness by the defendant physician who had been summoned by the sheriff. This examining physician saw him on two occasions for less than five minutes, and death occurred the next afternoon. An autopsy revealed the deceased had no alcohol whatever in his body but that he did have a complete coronary occulsion of the descending left branch, terminal dilation of the heart, chronic fibrous myocarditis with brown atrophy, acute terminal pulmonary edema, and a small hemorrhage in the right cerebral lobe. By merely analyzing a specimen of the deceased's urine, blood, or saliva, this examining physician could have quickly ascertained that the deceased was not intoxicated but critically ill, and proper medical treatment might have been administered in time. The personal grief to this physician of a malpractice action could have been avoided.

Truth Serum

The administration of sodium amytal or metrazol to patients believed to be feigning their physical or mental conditions, or otherwise prevaricating, is being used in an increasing number of criminal cases. This medical technique, generally known to the courts and attorneys as the use of truth serums, tends to remove the conscious inhibitions of a patient. While under the influence of these drugs, the patient's normal pattern of behavior appears and questions are apparently truthfully answered.

Because their scientific accuracy has not as yet been established, the truth serum technique has been largely limited thus far to the field of crime detection. In that respect they are already serving a most useful purpose. But testimony as to a patient's statements while under the influence of these drugs is generally held inadmissible in evidence. Indeed, some courts actually ridiculed the efficacy of truth serums when the question of their admissibility was first presented. In 1926 the Supreme Court of Missouri commented:[37]

> "Testimony of this character . . . is, in the present state of human knowledge, unworthy of serious consideration. We are not told from what well this serum is drawn or in what alembic its alleged truth-compelling powers are distilled. Its origin is as nebulous as its effect is uncertain. A belief in its potency, if it has any existence, is confined to the modern Cagliostros, who still, as Valsamo did of old, cozen the credulous for a quid pro quo, by inducing them to believe in the magic powers of philters, potions, and cures by fake. The trial court, therefore, whether it assigned a reason for its action or not, ruled correctly in excluding this claptrap from the consideration of the jury."

But to secure a graphic picture of the law's valiant struggle over the past two decades, to keep abreast of the rapid development in this field of medical science, attention should be drawn to a recent New York case involving the truth serums.[38] In a prosecution for murder, the defense produced was alleged insanity. A psychiatrist at Bellevue Hospital who had examined the accused while under the influence of sodium amytal and metrazol was permitted to testify that the defendant's symptoms, while under the influence of these drugs, did not fit into any pattern of insanity or any form of psychosis. The defendant was convicted. He appealed to New York's highest court, claiming error in the admission of this testimony. The court in sustaining the conviction, commented:[38]

> "The court, under the circumstances presented here, may not control the methods which have been determined by the medical profession to be proper means for discovering or treating mental diseases."

But the court added:

> ". . . We do not pass upon the question whether the testimony of the examining and observing psychiatrist was admissible to establish a confession of guilt or admissions evidencing guilt while the defendants were subject to the influence of the drugs which had been administered to them. We are not now prepared in view of the record presented here and of the present medical knowledge and experimentation disclosed therein, to hold that such testimony is competent. The questions asked in this instance were quite evidently for the purpose, among others, of determining whether defendants were capable of understanding the proceedings and of making their defense."

37. State vs. Hudson, (Mo.) 289 S.W. 920, 921 (1926).
38. People vs. Esposito, (N.Y.) 39 N.E. (2d) 925 and 928 (1942).

How far the law advances in the future recognition of the competency of the truth serums depends strictly upon their degree of accuracy as established and acknowledged by the medical profession.

Also of great assistance in detecting and exposing the would-be deceiver has been the development of a certain scientific apparatus commonly known as the lie detector. In this deception test, a blood pressure cuff is applied upon the upper right arm to record changes in the blood pressure and pulse rate, a pneumograph tube is put around the chest to record changes in respiration, and electrodes are attached upon the left hand to record the psychogalvanic reflex or electrodermal response. Questions are asked at twenty-second intervals with irrelevant interrogations being interspersed among the crucial questions. The most reliable indication of deception is the simultaneous suppression in respiration and an increase in blood pressure immediately after the subject's answer. Deception may also be indicated by a specific response in either blood pressure or respiration. Heavier breathing at the end of the test record, a slowing up of the subject's pulse beat at the time of his reply to a question, and a sharp drop in a subject's blood pressure tracing several seconds after the subject's answer are other less reliable indicia of deception.[39]

To be indicative of a falsehood, there must be a deviation of the blood pressure, pulse, or respiration from the subject's norm, which is established on the record by his reaction when irrelevant questions or no questions at all are being asked. This deviation to be significant should also appear on a second test.

The chief source of error is said to be in its failure to detect deception in the guilty individual, rather in the misinterpretation of an innocent subject's record. This failure arises from the "stoic's" lack of fear in being detected and results in the subject having no physiological changes on which the lie detector apparatus might operate. Persons of inferior intelligence and abnormal mentality are more apt to be devoid of this fear.

The lie detector does detect deception with a considerable degree of accuracy and has a psychological effect upon the subject, often inducing admissions of truth and confessions of guilt. Such admissions and confessions are admissible in evidence in our courts.[40] However, the test records and the examiner's interpretation thereof are generally held inadmissible on the theory that the tests have not yet gained such standing and scientific recognition among medical authorities as to make them reliable proof.[41]

Some physicians and surgeons are disinclined to accept cases of personal injury, occupational disease, or other matters likely to result in legal proceedings. The one who has a high standing in the profession and whose medical testimony is always impartial is conspicuously present in this group. He is motivated by what appears to him as certain distasteful aspects of such cases. He has learned from experience that some patients expect assistance in establishing mala fide claims. The malingerer believes his physician will actually falsify his prognosis or exaggerate the degree of disability. A few, unfortunately, have the temerity to expect a physician to risk his professional reputation in establishing a casual relationship between injury and remote physical condition. While there may be a few physicians who allow their better judgment to be influenced by sympathy or a misguided sense of loyalty to the patient, most physicians ignore the patient's subtle suggestions and report his true physical condition when inquiry is made by those interested. The doctor's moral duty to give all persons his professional attention, and his civic duty to expose the would-be deceiver, and assist the courts in the just determination of litigation, when thoroughly considered by him in a proper perspective, should overcome any reluctance he may have toward testifying.

Medical Witness

Some doctors also believe court appearances to be time-consuming, disruptive to office and hospital routine, as well as lacking in proper remuneration. However, there is a growing tendency on the part of attorneys and courts to co-operate with the physician witness as to the date and hour most convenient for him to appear. Almost invariably, attorneys will interrupt the proceedings upon the doctor's appearance to place him promptly upon the witness stand. Expert

39. "The Lie-Detector" by Fred E. Inbau, *Boston University Law Review*, April, 1946.

40. Com. vs. Hipple (Pa.) 3 A. (2d) 353 (1939); Com. vs. Jones, 341 Pa. 541, 19 A. (2d) 389 (1941).

41. People vs. Becker, 300 Mich. 562, 2 N.W. (2d) 503 (1942); People vs. Forte, 279 N.Y. 204, 18 N.E. (2d) 31 (1938); State ve. Bohner, 210 Wis. 651, 246 N.W. 314 (1933). See, also, annotations in 119 ALR 1200 and 139 ALR 1174. But see People vs. Kenny, 167 Misc. 51, 3 N.Y.S. (2d) 348 (1938) where the defendant was permitted to introduce in evidence results of pathometer test indicating his innocence.

witness fees now granted by the courts more nearly compensate him for the time involved.

Some physicians also dislike the arduous task of explaining medical histories and principles in a layman's language, and believe the cross-examining attorney will attempt to take advantage of any confusion to twist his medical testimony, by clever questioning, into refutations and contradictions. The court of today does not permit at attorney to badger, belittle or browbeat a reputable medical practitioner. Medical witnesses can expect to receive the respect and consideration of all court attachés to which their high achievements and professional calling entitle them.

Of course, the physician can himself considerably expedite his time in court. Conferring in advance with counsel so that each fully understands the medical and legal phases of the case will greatly reduce the number of questions propounded at the trial. In so conferring ahead of time, the attorney may be of assistance to the physician in the employment of such layman's language in explaining the medical testimony involved, that it may be quickly grasped by the court and fully understood by the average juror.

The medical witness should not volunteer testimony or appear too eager in testifying. He need only answer clearly and frankly the questions asked, addressing his remarks to the jury or the court, if sitting without a jury, in a clear and audible voice. An instant's pause for deliberation before answering crucial questions will not only lend more authority to the physician's testimony but give him a little time to organize his thoughts and carefully phrase his answer.

A very grave duty rests upon the doctor not only to do all in his power to attend and cure the physical ailment, but also contribute his knowledge to the ever present quest of truth. He should co-operate fully with the courts in appearing and testifying when requested. He need have no reluctance in so doing. He will be treated with utmost respect and courtesy, and, incidentally, may broaden his knowledge of human nature and the laws that govern his daily life. To the ever-busy doctor who complains that he has not the time to attend court, I would give the following prescription: An interruption of your daily routine, a little relaxation from the pressure of your daily grind, will add years to your life.

As the old Chinese proverb so aptly states it: "Enjoy yourself, it is later than you think."

SCARLET FEVER TAKES NEEDLESS TOLL IN UNITED STATES

An average of 455 persons still die of scarlet fever in the United States every year, writes George F. Dick, M.D., a member of the faculty of the School of Medicine of the University of Chicago, in the current issue of *Hygeia,* health magazine of the American Medical Association.

"The United States Public Health Service reports that during the five-year period 1940 to 1944 inclusive, 2,275 persons died of scarlet fever in the United States," Dr. Dick says. "In the same period more than 700,000 persons in this country suffered from the disease and its insidious complications. . . .

"It is true that in this country scarlet fever is in a phase of *comparative* mildness. Epidemics have been recorded in which half of those who took the disease died of it. The Public Health Service figures, an average 455 deaths a year with 141,241 cases, represent a mortality of less than one per cent. . . .

"These figures, however, do not give a complete picture. What the United States Public Health Reports are unable to supply is statistical information on the incidence of complications following attacks of scarlet fever." Actually, Dr. Dick reports, scarlet fever is a disease with 34 per cent of complications, including deafness and Bright's disease, and each of these complications is likely to lead to others.

"It is probable that carelessness, thoughtlessness and ignorance are the chief reasons why preventive measures are not used more than they are, for the preventive measures have been in wide use for many years," Dr. Dick continues.

One of the most common misconceptions, he believes, is that scarlet fever antitoxin only prevents the scarlet fever rash. "The fact is," he explains, "that it prevents scarlet fever as a whole, and any and all infections with scarlet fever streptococci."

Detroit Physiological Society

Session of December 18, 1947

Vitamin A and Carotene in Nutritional Status Studies at Five Michigan Child-Caring Agencies.

Ann P. Harrison, Abner R. Robinson, Elsie Z. Moyer, and Eliot F. Beach, Research Laboratory, Children's Fund of Michigan, Detroit.

In studies of the nutritional status of children in the care of five urban and rural agencies, vitamin A and carotenoids were determined in the blood serum of 350 boys and girls two to eighteen years old. Blood samples were obtained from finger punctures for analysis by recently developed micro-spectrophotometric techniques. Actual intakes of carotene and vitamin A by four representative children were determined by spectrophotometric analysis of the food each consumed during one week in the autumn and spring.

Blood serum vitamin A concentration showed greater constancy than that of carotenoids, both from day to day and between seasons. For the groups of twenty-six to seventy-nine children in the care of the five agencies, mean vitamin A in the spring ranged from 29 to 34 micrograms per 100 ml., and in the fall from 31 to 42 micrograms, with the highest fall values occurring for children living in suburban Detroit and the lowest for children in the Upper Peninsula. The mean carotene values ranged from 99 to 146 micrograms per 100 ml. in the spring, and from 100 to 185 micrograms in the fall, the highest spring and fall values occurring in suburban Detroit and the lowest for children in the Upper Peninsula. The higher values occurring in the fall were due largely to greater concentrations of vitamin A in foods available in summer. However, factors other than diet, such as incidence of infections and environmental conditions might account for a part of the variation. In one group a marked increase in carotenoids and a slight increase in vitamin A were observed at the end of a six weeks' period of nutritional conditioning in a health camp. The data emphasize the importance of furnishing foods containing liberal allowances of vitamin A for children in the care of agencies.

Sternochondral Joints in Man.

D. J. Gray* and E. D. Gardner, College of Medicine, Wayne University.

The examination of the sternochondral joints from several hundred bodies in the dissecting room has revealed the presence of fibrocartilage in all of these joints. An interarticular ligament was present in the second joint in less than half the cases. In this and other joints the fibrocartilage at times obliterated the cavity, either partially or entirely; at other times it assumed the form of strands which passed across the cavity, usually in an oblique direction. In the remainder it merely formed a covering, on either side of the cavity, for the sternal and chondral articular facets.

Since fibrocartilage is present in none of the sternochondral joints at birth, its time and manner of origin is at the present time speculative. Present indications are that it arises from the capsule, or its synovial layer, at one or both extremities of the joint and carries its blood vessels with it as it forms the lining for the cavity.

It seems likely that the fibrocartilage arises in response to the unusual mechanical stresses brought to play at these joints. The repetition of movement and the movements in many directions bring about conditions which do not obtain in other joints.

Microbiological Determination of Folic Acid.

O. D. Bird, Parke-Davis Research Laboratories.

Early fractionation work on folic acid in our laboratory was guided by assaying antianemia activity in the chick. At the same time microbiological assays of an unknown factor in yeast and liver were being carried out. An article published by the Wisconsin group correlating these two activities caused us to cross check our fractions and we found a parallelism. After this the microbiological assay was used as a guide in concentration of the factor from liver.

Yeast extracts were rich in chick activity but had little microbiological activity. This led to the

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suspicion that folic acid occurred naturally in a conjugated form which required an enzyme for cleavage. This enzyme, called conjugase, was found in many animal tissues and a study of its characteristics was made. A practical enzymatic digestion procedure to be used prior to microbiological assay was worked out and found to be applicable in many cases.

This enzymatic reaction is not always successful due to the action of natural inhibitors. This prompted a study of these inhibitors to find ways of counteracting their effect. Further improvement of the microbiological determination of folic acid in natural substances where it occurs in conjugated forms depends on more complete elucidation of these inhibitors which affect conjugate action.

Session of January 15, 1948

"Stresscoat" Analysis of the Human Femur.

F. Gaynor Evans, H. R. Lissner and Herbert E. Pedersen, Departments of Anatomy and of Engineering Mechanics, Wayne University.

Sixteen "stresscoat" tests were made on ten femora loaded statically and fourteen tests on fourteen bones loaded dynamically. The load was applied to the head of the vertically oriented bone. Six bones were tested under both methods of loading. The static loading was done in a materials testing machine under loads of 400 to 1280 pounds. In the dynamic loading tests 15.8 inch pounds of energy were used.

With both types of loading the resulting deformation pattern of cracks in the "stresscoat" lacquer was chiefly on the superior aspect of the neck and on the antero-lateral aspect of the shaft. These are the tension sides of the bone when loaded vertically, and the cracks are transverse to the direction of tension stress.

The time of appearance of the cracks under static loading indicates the femur is a uniform strength member. Static loading also showed that the femur behaves as an elastic body. Generally, the cracks were more numerous and the deformation pattern better developed under dynamic loading.

The tests showed that the region of greatest weakness of the shaft is governed by its curvature. The "stresscoat" pattern and actual fracture clearly show that failure occurs from *tension* stress in the bone.

The location and direction of fracture under sufficient load can be predicted with fair accuracy from the "stresscoat" deformation pattern.

Strain Differences in Response to Diethylstilbestrol and the Induction of Mammary Gland, Adrenal and Bladder Cancer in the Rat.

W. F. Dunning, M. R. Curtis and A. Segaloff, Department of Pathology, Wayne University College of Medicine in co-operation with the Detroit Institute of Cancer Research, Detroit.

Pellets weighing from 15 to 25 mgm. of compressed crystalline diethylstilbestrol were implanted in the subcutaneous tissues of the scapular region of thirty rats of each sex of each of four distinct inbred lines. Repeated implantations followed the complete absorption of the previous pellet as long as the rat survived. The rats of the four lines varied in survival, in absorption rate of diethylstilbestrol and in resultant pathological lesions. The most conspicious lesions included pituitary adenomata, fatty livers, bladder calculi and associated bladder papillomata with Grade I squamous cell cancer, increased secretory activity of the mammary gland with extensive hyperplasia and with many microscopic foci which appeared neoplastic.

Pellets of cholesterol containing from 4 to 15 mgm. of diethylstilbestrol were implanted in the scapular region of a second series of thirty rats of each sex of each of the same four inbred lines. The diethylstilbestrol was more slowly absorbed from these pellets and no reimplantations were necessary to keep the rats in a constant state of hyperestrinism for the remainder of their lives. Among the rats which survived for eight or more months after the beginning of the treatment, multiple mammary cancers were observed in 17 or 68 per cent of the males and 22 or 78 per cent of the females of one line and in 7 or 58 per cent of the females and 23 or 74 per cent of the males of another line. Solitary mammary cancer was

found in one (11 per cent) of the females and five (18 per cent) of the males of another line, and no mammary cancers were found in the males or females of the fourth line. Rats of the latter line outlived those of the former by several months and twenty-two (73 per cent) of the males and eight (30 per cent) of the females developed bladder calculi. Sixteen males and six females of this line had bladder papilloma or squamous cell cancer associated with the calculi. Bladder calculi were observed in five males and nine females of another line, and two males and fours females of this line had associated bladder papillomata and squamous cell cancer. Three males of the latter line developed cortical adenoma of the adrenal and one female and three males had metastasizing adenocarcinoma of the adrenal cortex. The mammary cancers included 142 papillary adenocarcinoma, fifteen adeno-acanthoma, four solid carcinoma, two solid carcinoma with papillary areas, one interductal carcinoma, one squamous cell cancer, and five which were unclassified.

Effect of Urethane on Malignant Diseases. Clinical, Hematologic, and Histologic Observations on Patients with Carcinoma, Leukemia and Related Diseases.

Lawrence Berman and Arnold R. Axelrod

The literature now contains reports of approximately 100 cases of leukemia and other malignant diseases treated with ethyl carbamate. In our study of ten patients, the following observations were made.

The effects of urethane (ethyl carbamate) therapy are variable and, as yet, unpredictable in any given case. The most consistent results have been obtained in patients with chronic leukemia, particularly of the myeloid type. There are no reports of retardation of the progress of acute or terminal leukemia.

Most patients tolerate oral administration of urethane. Clinical manifestations of toxicity are slight drowsiness or dizziness, nausea and vomiting. The latter may be obviated by administering the drug per rectum, intramuscularly, or intravenously. Weight loss, out of proportion to reduced food intake, may represent an important constitutional injury to patients receiving the drug.

Hematological improvement may be independent of the changes in the general status of the patient. Urethane causes a fall in the absolute numbers of both lymphoid and myeloid leukocytes in the peripheral blood of patients with normal or leukemic leukocyte counts. Severe temporary hypoplasia of all elements of the bone marrow may result from over treatment and may progress after treatment has been stopped.

Urethane causes regression but not complete disappearance of enlarged lymph nodes and spleens in patients with leukemia.

Leukemic foci in various organs may be reduced in extent. The results obtained up to now warrant further investigation of urethane and its derivatives in the treatment of malignant neoplastic diseases in man.

MSMS

BLOOD SUGAR

Today 90 per cent of the medical profession requests a fasting blood sugar test for the diagnosis of diabetes. In my twenty-eight years of experience, I have found that this does not alway prove satisfactory. For example, a person with a high blood sugar level after a meal may show an absolutely normal blood sugar on a fasting diet. Also in the glucose tolerance test, the first blood sugar may be 90 or 100 mgms, of sugar of glucose per 100 c.c. of blood, and thirty minutes after administration of glucose, according to body weight, it will be 225 mgms. An hour and a half later it may be 275 to 300 mgms. and then it will gradually come down to 120 mgms. or less. This is a positive case of diabetes. Therefore, unless a person is known to be diabetic where medication and diet must be controlled through blood sugar tests, I suggest that besides the glucose tolerance test the following examination be given.

Have the patient eat a hearty breakfast with a liberal dose of sugar (4 to 6 teaspoonfuls of sugar on cereal and to 2 to 3 teaspoonfuls of sugar in coffee). The blood sugar is then taken two hours after the meal. The results from this analysis will show that a non-diabetic patient will have a normal sugar between 80 to 120 mgms., and a diabetic patient will have a sugar that is higher than normal. In cases of a borderline reaction, where the blood sugar is slightly above normal, the patient may never suffer real diabetes, if diet and medication are regulated, because the Langley gland may not have been permanently destroyed.

For this type of examination, the blood sugar should be taken two hours after the meal and sent to the laboratory as soon as possible.—M. S. Tarpinian, B.S., Detroit.

A review of the records of the Veterans Administration discloses that the nation's veteran population has reached a new peak of 18,569,000. Of this number, 14,685,000 are veterans of World War II, and 3,884,000 from all other wars, and the regular establishment. The present veteran population is three times that of July, 1945.

Public Relations

President's Page



There was a time when the physician-patient relationship was all that was necessary for good public relations in medicine. Unfortunately, that time has passed. In recent years "Adequate Medical Care" has become a political football for several groups whose primary interest is not the care of the sick. Among these would-be ball carriers may be mentioned the Federal Security Agency, certain union officials. and those individuals who sincerely believe that the future welfare of this country lies in the direction of socialism. Without questioning their motives, we seriously question their judgment on matters pertaining to medical care. It is up to us to keep constantly before the public the fact that the interests of individual and community health are best served through the practice of medicine as a free enterprise on a private patient—personal physician basis.

The Michigan State Medical Society has a rather extensive public relations program. We have an able Public Relations Counsel and an enthusiastic Public Relations Committee whose membership represents every part of the State. They are doing a splendid job, but they need your help. Within the next few months our Public Relations Counsel, Hugh W. Brenneman, will visit many of the county medical societies to bring you first hand information on what is being done and to call attention to some matters that remain to be done and that only you can do. Please make these meetings a success by getting your members to turn out en masse for them.

We feel confident that all members of the Michigan State Medical Society will continue to build sound public relations at the grass roots level by taking a deep personal interest in each patient, by rendering service when and where needed, and by making no charge that is out of keeping with the patient's ability to pay.

P. L. Ledwidge

President, Michigan State Medical Society

Editorial

WORLD'S FIRST BILL OF RIGHTS

A COMMISSION representing the United Nations met recently in Geneva, for a conference on Human Rights, and on December 18, 1947 forwarded a report to the United Nations which its General Assembly will be asked to adopt. Mrs. Franklin D. Roosevelt was chairman of the commission. Article IX reads:

"Everyone has the right to a decent living; to work and advance his well being; to health, education and social security. There shall be equal opportunity for all to participate in the economic and cultural life of the community."

This bill of rights attempts to give to everyone, all over the world as a right certain things that are desirable, but things that are best enjoyed if they are earned, things that give the greatest benefits to those who have demonstrated their worthiness by willingness to work. Considering these "Rights" as *rights* means socialism. It means that everyone is equal, a condition we all know is not true. Some men are born with handicaps or defects. These cannot be made equal by legal enactment, no matter how much we try. We must accept conditions as they appear.

Elsewhere in this number of THE JOURNAL we are quoting from the President's messages and budget showing that an appropriation is asked to put into effect the first categories of the compulsory health program. Arthur J. Altmeyer is talking of "public assistance" now. This is to be expanded. The plan is not impossible. All that is necessary is to repeal those parts of the present Social Security Act which provide categorical asistance to dependent children, the aged, and the blind, then add a new title which would provide that anyone in need, old or young, employed or unemployed, would be entitled to public aid.

Federal grants-in-aid would bring us back to WPA, FERA, and the whole federal relief business. The Wagner-Murray-Dingell coupe would be complete, and through the back door. The groundwork is now being laid.

Is the World's First Bill of Rights to be the World's *Worst* Bill of Rights?

INSIDIOUS? WHAT DOES IT MEAN?

TO CARRY OUT the provisions of the U. S. Hill-Burton Bill and its Michigan counterpart, a Public Act 299 of 1947, and to secure for Michigan the benefits promised for constructing hospitals, the Governor appointed an Advisory Council. This Council asked for a committee, representing interested organizations, to meet and suggest the legislation which would be needed to qualify for the federal grants. It is the opinion of the Governor's Advisory Council that some changes must be made in Act No. 299, to make it conform to federal provisions, but the changes are minor. The legal advisor of the Michigan State Medical Society believes that the present Act meets the requirements of the Federal Act, that the Federal Act does not require the licensing of hospitals.

A proposed draft of amendments to Act No. 299 of the Public Acts of 1947, entitled "The Michigan Hospital Survey and Construction Act," was presented and studied. It was the fixed opinion of delegates representing some interested groups that a licensing provision should be attached to the present bill, and it seemed opportune to write an all-inclusive hospital licensing bill. This produced about ten typewritten pages of amendments and additions to be submitted to the legislature. It was pointed out to the committee that a very simple amendment, merely changing a few words for clarification to assure the present act's authorizing licensing where it now authorizes registration would be much easier to accomplish. The committee decided on trying for a general licensing act as an amendment.

At the end of the committee's work, a representative of the Michigan Association of Osteopathic Physicians and Surgeons, Inc. presented the following innocuous appearing paragraph to be included in the Act:

"No rule, regulation or standard shall be established or enforced under the terms of this Act having the effect of depriving patients or physicians in a community of existing or proposed hospital facilities, unless the use of other suitable hospital facilities complying with the rules, regulations, and standards of the State Board of Health are available for the use of all physicians and patients of the community."

Was that innocent? Would it have opened up all the hospitals of the State to the osteopaths? That measure may be attempted in the Legislature, and it must be anticipated.

INDUSTRIAL MEDICINE

A NEW FIELD of specialization in medicine is being developed in conformity with the rule that a growing need must find an answer. Originally, we were mostly an agricultural nation, but parts of the nation, our own state outstandingly, have become highly industrialized.

Industry can only succeed if its needed labor is trained and constantly available. Turn-over of labor is expensive. The training for specific skilled jobs is long and costly, and absenteeism is calamatous. The maintaining of constant and efficient labor is so necessary to successful industry that personnel departments are rapidly increasing in use and in functions.

The interest of medicine in this modern phase of life in a country being gradually industrialized was first in caring for the sick and injured, and this was only natural. We are doing curative medicine. In the early days, and until about a quarter of a century ago, a laboring man had to assume his own risks of accident or sickness. If injury or sickness caused by negligence of the employer could be proven in court, the laborer could get damages. Social advancement, efforts of wise labor leaders, and the foresight of many employers of labor gradually created a new era and ensured the passage of laws governing liability for injury or disease and assessing that liability through the employer to the costs of manufacturing, and the costs of the finished product—where it belonged.

Medical care was more commonly used, the general practitioners became interested, and "industrial surgery" began to develop. Some employers of labor engaged their own surgeons to care for their injured, or to supervise that care, on the theory that these "surgeons," by doing more of this work would become more efficient and more valuable. They would render more exact services to the injured, and would by that very fact render better service to the industry. Consequently, there has grown up a broad field of highly skilled service, with many men throughout the country being recognized as industrial surgeons.

Industry is ever becoming more intense and skilled labor more difficult to find and train. Continued service is now absolutely essential to efficient and successful industry. Workers and unions are demanding more protection, and industry is begging for more efficient medical service. It is not enough to treat the patient and get him healed from his injury or his industrial disease. Now the *sine qua non* of good medicine is becoming the ability to get the patient back to work in the shortest possible time with the least possible handicap.

Medicine must intimately understand the conditions and hazards of labor, and provide the quickest and best relief, not considering healing the goal, but complete reconditioning, mental as well as physical. This is one of the challenges of the immediate future.

"CHISELING DOCTORS—SKUNKS"

THE NEW CHIEF of the Veterans Administration Medical Department chose those words in describing doctors, and demanding that the American Medical Association clean its own house. This story was reported in the January 15, 1948 *Detroit Free Press* as a front page article, gaining the greatest possible publicity. Dr. Paul B. Magnusen says he will submit the names of these "skunks" to the American Medical Association for discipline. He will not tolerate victimization of his Veterans Administration beneficiaries.

This reminds us of an occasion a few years ago when the American Medical Association was being accused of breaking the Sherman Anti-trust law. The Assistant Attorney General, Thurman Arnold, tried his case deliberately in the public press, attempting to discredit the American Medical Association. He used liberally newspapers, magazines, public speeches, telling what he had "proven" against the American Medical Association in the Grand Jury. (Incidentally, nothing is proven in the Grand Jury—that is simply a hearing supposed to be in secret to determine whether there is sufficient evidence to justify an indictment.)

Dr. Magnusen is now doing the same thing. He has made no charges against individuals, but against the whole profession. Wrong doing has not been proven, but the whole profession stands convicted. Unfortunately, people read the newspapers and believe what they read. More harm has been done to the good repute of all physicians than the known good works of the whole profession can counterbalance.

These criticisms and charges might have been

made against some individual, and that act might have been excusable. But making the assertions against the whole profession cannot be excused.

Dr. Magnusen can hardly hope to gain full-hearted co-operation from the one group which can make his medical program a success by calling them "skunks."

LONG WAR SERVICE OVERSEAS

IN WAR it is one of the duties and one of the privileges of citizenship to serve in the military forces. Within a short generation, there have been two world wars calling for our men to serve many months overseas. This need of armies and fighting forces calls also for the service of doctors. World War I was of comparatively short duration but called for service overseas of varying times. The Editor knows of many of our Michigan doctors who served eighteen months or more in foreign service. We were sorry for ourselves because of the necessary separation from our families. Many believed that some method of rotation of foreign service should have been instituted.

But World War II was much longer and called for longer periods of service, especially overseas. Many of our soldiers were gone, without chance of furlough home, for impressive periods of time. One detachment sailed for Iceland September 4, 1941 and landed in New York July 18, 1945, a period of forty-six and one-half months. This was a force of about 2500 of the Fifth Division, and of this number about forty-five served the whole time abroad.

We are firmly of the belief that no man is so indispensable to the service as to demand such sacrifice. The Government does not have the right to demand that much of anyone's life. If that man is so essential, some consideration should be given him, and at least a trip home would strengthen his morale.

We are interested in this matter, and would like to know what is the longest uninterrupted overseas service among our military members. Will some of our members who think they may be the unlucky mortals to have established a record write us telling dates of departure and return, and the time; also the locale of the service. If this number with unusually long overseas service is large, we shall publish the results of this survey. Our object is to establish a sense of fair play, and a program of rotation of service.

DOCTORS FOR RURAL PRACTICE

NOW WE HAVE the plan in Michigan. Many times it has been suggested that some plan be evolved to establish scholarships for students who would agree to practice for a term of years in rural areas. At the annual meetings of the membership and of the Board of Trustees of the Michigan Foundation for Medical and Health Education, Inc., provision was made for the Foundation to establish and administer a fund to provide scholarships to secure medical practitioners for rural areas. The plan is not yet complete, but it is hoped that it will get results as soon as possible.

Suitable scholarships will be established starting in the senior year, when some students may find need for help and be willing to promise services in rural areas. Internes and those ready for practice also may apply. Equipment and a start in practice are available, if needed. The plan was launched with an appropriation of five thousand dollars, a promise of three thousand for a starter and to advance the effort, the Foundation to be the custodian for any monies that may be available. Until now there has been plenty of wishful thinking, with no fund ready or group ready to administer such a fund.

This plan in Michigan is not new; it has been awaiting leadership. The Michigan Foundation for Medical and Health Education is naturally fitted for the post. It was established for the purpose of promoting medical and health education. Thus the Foundation is getting actively established in its chosen function. Several other states have programs: Virginia has had one for several years, and now has twenty scholarships; Alabama has a scholarship for each county, with sixty five students in school now; Illinois has a $100,000 revolving fund, from the Medical and rural people; Indiana has six $500 yearly scholarships from the Medical Association; Kentucky raised $150,000 for scholarships; the Mississippi legislature appropriated $300,000 and has seventy-three loans to date; South Carolina has fourteen $550 annual scholarships for practice in rural areas for a time equal to the length of the scholarship; Wisconsin has a bill in the legislature for a $20,000 fund.

Michigan now is not lagging, and we anticipate a rapid growth of the plan. The Foundation is actively working on the committees and administrative procedure.

Congratulations to our *active* Foundation!

Michigan on the March Against Rheumatic Fever

A militant attitude coupled with aggressive action characterizes the campaign of the Michigan State Medical Society to fight rheumatic fever in Michigan.

Well known by doctors of medicine is the appalling toll in disability and death exacted by this dread disease. Unfortunately, the prospective danger to life and health inherent in rheumatic fever are less well known to the general public. The average person has a natural inclination when considering disabling and crippling diseases to think only of visible disabilities. Yet, recent figures indicate that rheumatic fever is second only to accidents in the cause of disability, and that it causes five times as many deaths as infantile paralysis, scarlet fever, diphtheria, measles, meningitis, and whooping cough, combined. Cold and colorless figures point to the awful fact that of every 1,000 of those attacked by rheumatic fever, fewer than half will be able to lead a normal existence. Ten years later, 203 will be dead, 344 compelled by residual heart disease to limit activities, and 135 forced to lead a sedentary existence.

Handicapped by lack of funds, medical scientists are doggedly searching for the answer to the rheumatic fever riddle. The wide discrepancies in the amount of money used for medical research in this disease can be indicated by comparing the figures spent for another dread disease—infantile paralysis. For every death due to infantile paralysis $525.00 is spent for medical research. For every death due to rheumatic fever a pittance of 17c is available for research purposes. Yet, progress is being made and medical journals throughout the country are revealing new facts, throwing light upon the characteristics of the disease and new methods of treatment which lighten its fearful effects.

Michigan Leads the Way

Foremost among the states carrying on programs for the eventual control of rheumatic fever is Michigan, under the direction of the Michigan State Medical Society Rheumatic Fever Control Committee. Since its inception in 1945, the Michigan program has increased from an original pilot control center at Marquette, under the direction of M. Cooperstock, M.D., in the Northern Michigan Children's Clinic, to thirty Rheumatic Fever Control Centers located in fifteen well defined districts covering the whole state. The greatest single addition to the program was made in January, 1948, when sixteen Centers were established in the major hospitals of Detroit and Wayne County. Michigan's program has attained national recognition; inquiries are received daily from other medical societies which, upon awakening to the opportunities for service on this disease front, are looking to Michigan for advice and help. Of the 3,000 counties in the United States, only 300 have Rheumatic Fever Control Center services. Yet, there are twenty-three programs in operation.



Fig. 1. This young lad has just been referred to the Rheumatic Fever Control Center by his family physician and is being examined by a doctor of medicine. The doctor will probably ask for laboratory tests to be made before he attempts to answer the question "Does Louis have rheumatic fever?"

In many instances, other states are using government funds to implement their program. In this respect they differ from Michigan, for not one cent of government money was or is used to organize, establish or maintain any center in this state. The advantage accruing to the program in

Photographs by Dale Rooks

scarcity of red tape—absence of retarding governmental regulations—maintenance of the doctor-patient relationship—and confidence in a program designed and directed by doctors of medicine—cannot be overemphasized. Nor should the vision and leadership of those who inaugurated the present concept and put it into aggressive action go unappreciated. The greatest proponents of the plan were L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society and Carleton Dean, M.D., Director of the Michigan Crippled Children Commission, Lansing. Dr.

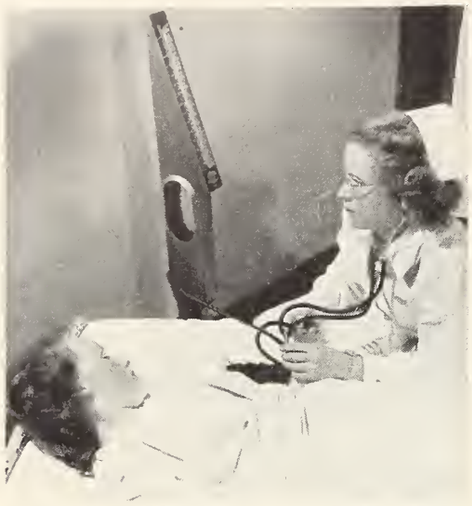


Fig. 2. A nurse at the Center takes the blood pressure on a suspected victim of rheumatic fever as one of the first in a series of tests.

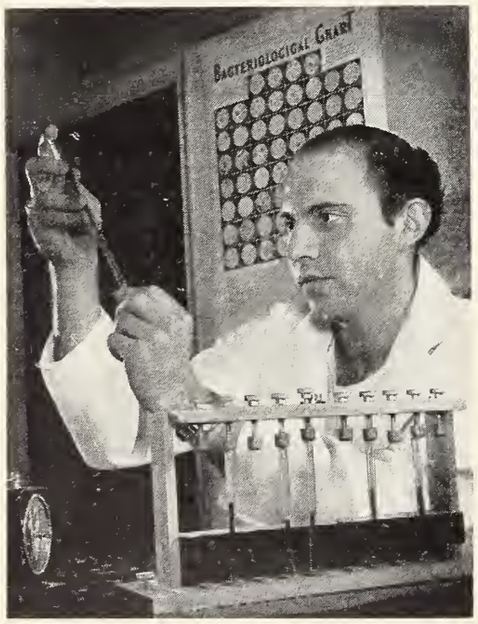


Fig. 4. A bio-chemist runs a blood sedimentation rate test on one of the Center's patients. Rheumatic fever is hard to diagnose, and this is one of the important tests in the series. A small charge is made to the patient for the laboratory tests, but if the child is unable to pay this cost the Michigan Crippled Children's Commission arranges to repay the hospital.



Fig. 3. While a visitor from the Alpha Phi Sorority watches, a cardiograph of the small patient's heart action is taken by the cardiographic technician and the nurse secretary of the Control Center. This is another test in the series to determine the presence of the No. 1 killer of children.

Foster was Chairman of the Rheumatic Fever Control Committee during the early years of planning and development. He was succeeded in 1946 by H. H. Riecker, M.D., of Ann Arbor, as Chairman. Emmet Richards, Alpena, President, and Percy Angove, Executive Director of the Michigan Society for Crippled Children and Disabled Adults, respectively, made available through their organization the original $15,000 grant which paid the initial cost of establishing the Centers and carrying forward their administrative expenses. Frank Van Schoick, M.D., Jackson, present Chairman of the Michigan State Medical Society Rheumatic Fever Control Committee, has ardently supported the plan, and under his leadership the Committee has added the Detroit Centers, developed under the direction of Norman E. Clarke, M.D., Detroit, Chairman of the Wayne County Medical Society's Rheumatic Fever Control Committee.

How the Centers Serve

The term "unique" defines the apparent ease of operation of the Centers. The normal routine is:

1. The family physician refers his patient to the Center.

2. Laboratory tests plus consultations between doctors of medicine especially experienced in rheu-



Fig. 5. General view of Rheumatic Rever Diagnostic and Consultation Center, as three army medical corps doctors, loaned to the Center for training in handling rheumatic fever control, take history, make auscultation and fill out reports.



Fig. 6. A general consultation follows the series of laboratory tests and examination. This is the hour of decision—a child's life rests in the balance.

matic fever then determine the diagnosis.

3. The patient is referred back to the family physician who receives from the Center a report of the diagnosis and recommended treatment.



Fig. 7. The child has been referred back to the family physician by the Center. The doctor and the secretary check the records for follow-up examinations. In some Centers, children are given periodic examinations every six months. A master file is kept at the Central Control Center at 2020 Olds Tower, Lansing, Executive Offices of the Michigan State Medical Society.

4. The family physician carries out the suggested treatment, and may re-refer the patient to the Center should additional consultation be desired.

5. The cases are kept on file in the Center, and a master copy placed in the central headquarters in the executive offices of the Michigan State Medical Society at 2020 Olds Tower, Lansing, where they are available for statistical studies.

These centers are diagnostic only. A minimal charge is made to every patient to defray the costs of laboratory testing. Doctors of medicine contribute their services in the consultative work. Should the patient be unable to pay the laboratory fee, the Michigan Crippled Children Commission defrays the cost. In borderline cases, where only part of the fee can be paid, the local chapter of the Michigan Society for Crippled Children and Disabled Adults steps in to help. The Alpha Phi Sorority has adopted Rheumatic Fever as a major interest, and is looking forward to carrying on educative activities and home visits.

Available results testify to the effectiveness of the program. Of the first 600 cases of suspected rheumatic fever referred to the Centers, 266 were diagnosed definitely as rheumatic fever. Over 2,000 children have been filtered through the Centers in a most thorough fashion since the beginning of the program less than two years ago. The Michigan Crippled Children Commission is referring patients to the Centers at the rate of over 100 per month. The Michigan Society for Crippled Children and Disabled Adults has placed on a yearly basis its contribution of $15,000 with more available if needed. But the MSMS Rheumatic Fever Control Committee is not resting on its laurels. It feels that the program has expanded smoothly and rapidly, but in doing so has indicated the tremendous amount of work which remains to be done before maximum effectiveness is reached. The problems of convalescent care for rheumatic fever victims has attracted the committee's thoughtful attention and the continued co-operative functioning of thirty Centers serving thousands of people is necessitating a continued increase in personnel and other complexities of operation. But the great start has been made—the future, filled with more and more effort, looks bright in the Michigan doctors' fight against rheumatic fever.

The fact that diagnosis of rheumatic fever is most difficult gives adequate reason for the existence of these Centers. Yet, in carrying out their function of diagnosis, new quantities of rheumatic fever victims are being revealed by the Centers and a higher incidence of the disease made known to exist than was heretofore suspected. It is something like the old fable of the tree which defied the woodsman's ax for whenever one chip fell to the ground, two grew in its place, and the great tree which threw a shadow over the entire kingdom continued to menace the lives of those in its malevolent shade. It was only when a young man with a magic ax and a stout heart placed his life in the balance and set his magic ax to work that the people were liberated from the tree's influence.

Perhaps the "magic ax" which will liberate our people from the dread blackness of rheumatic fever will be the MSMS Rheumatic Fever Con-

trol program placed and kept in action by the good thinking, hard work, and enthusiastic co-operation of every doctor of medicine in Michigan.

The present locations and committee chairmen of Rheumatic Fever Control Centers in Michigan are:

MICHIGAN STATE MEDICAL SOCIETY RHEUMATIC FEVER CONTROL COMMITTEE

Frank Van Schoick, M.D., Chairman

Central Office: 2020 Olds Tower, Lansing, Michigan

City	*Location of Center*	*Local Committee Chairman*	*Address*
Ann Arbor	St. Joseph Hosp.	H. H. Riecker, M.D.	Ann Arbor
Bay City	Mercy Hospital	L. Fernald Foster, M.D.	919 Washington Ave.
Grand Rapids	Blodgett Hospital St. Mary's Hosp.	Leon DeVel, M.D.	739 Plymouth S.E.
Jackson	W. A. Foote Memorial Hospital	Frank Van Schoick, M.D.	1301 Greenwood
Kalamazoo	Bronson	H. S. Heersma, M.D.	Amer. Bank Bldg.
Lansing	Sparrow Hospital St. Lawrence Hosp.	H. L. French, M.D.	301 Seymour Ave.
Marquette	Northern Michigan Childrens Clinic	M. Cooperstock, M.D.	Marquette
Pontiac	Pontiac General Hospital	D. S. Smith, M.D.	824 Riker Bldg.
Saginaw	Jarvis-Yawkey Court 200 S. Jefferson	David Gage, M.D.	217 S. Jefferson
Traverse City	Central Michigan Childrens Clinic	Mark Osterlin, M.D.	Traverse City
Detroit	16 Centers have been set up in Wayne County. Contact the Wayne County Medical Society, 4421 Woodward Ave., Detroit (Telephone Temple 1-6400)	Norman Clarke, M.D.	Polyclinic Bldg. 2501 W. Grand Blvd.

Additional centers are being organized in Alpena, Battle Creek, Port Huron and Muskegon.

SOME BENEFITS OF MEMBERSHIP—MSMS

Professional — Educational — Economic — Sociologic

1. Enjoyment of a position of trust and social responsibility in the community resulting in the opportunity to assume leadership in all medical matters.
2. Safeguarding your common interests through the vigilant work of democratically selected officers and committeemen who are men of your own kind: (a) who know your problems and those of your patients; (b) who serve generously without compensation; (c) who need and ask for your co-operation and advice.
3. Maintenance and constant improvement of standards of medical practice for the protection of patients.
4. Protection against state and national legislation inimical to public interest and the advancement of medical science; constructive efforts to initiate beneficial health measures; important contacts to effect the proper administration of existing laws.
5. Information and technical advice in medical-legal matters.
6. Defense of your profession and your source of livelihood against encroachments from without.
7. Opportunity to participate actively in planning, organizing and operating public service health programs sponsored by your medical societies (such as voluntary service plans, rheumatic fever control centers, et cetera)
8. Authentic information to an inquiring public regarding good medical service and the standing of practitioners.
9. Publication of a monthly Journal of high quality containing the latest scientific literature as well as medico-economic information important to you.
10. Opportunity to participate in an active public relations program designed and working in the interests of the public, your profession and yourself.
11. Personal service of your Executive Office in Lansing in matters associated with your practice of medicine.
12. Your medical societies act as sales ambassadors of the medical profession in your community and in the state.

The returns you receive from membership in the Michigan State Medical Society are almost unlimited. Your destiny is intimately related to the success of your county, state and national medical organizations.

Annual Session of the Council

January 23-24, 1948

HIGHLIGHTS OF THE SESSION

- Auditors (Ernst & Ernst) Report for 1947, and Budgets for 1948 approved. (See pages 325-328).
- Annual Reports of Secretary, Treasurer, Trustee, Editor, and three Committees of The Council accepted.
- Secretary L. Fernald Foster, M.D., Treasurer A. S. Brunk, M.D., and Editor Wilfrid Haughey, M.D., re-elected.
- Michigan's Foremost Family Physician Award created—the Award for 1947 going to T. E. DeGurse, M.D., Marine City.
- Dues of Military Members in active service remitted for the year 1948.
- Dissolution of Trusteeship between Michigan State Medical Society and Wm. A. Hyland, M.D.—which in 1940 closed out medical-legal activities of State Society—approved.
- Proposed Hospital Licensing Bill studied and referred to special committee of The Council to confer with other interested groups.
- Immunization Month (February, 1948) endorsed.
- Program of using Medical Consultants to aid Vocational Rehabilitation approved.
- A. S. Brunk, M.D., Detroit, P. A. Riley, M.D., Jackson, and D. R. Smith, M.D., Iron Mountain, nominated to Board of Directors of Michigan Hospital Service.
- Adopted MSMS Rheumatic Fever Control's statement re campaign for funds to aid in control of heart disease:

  "Increased financial support for study and care of heart disease, of which Rheumatic Fever is a prominent part, is desirable.

  "A national campaign to support this work is in preparation. The pioneering experience of the MSMS warrants that in any such program in this state, the MSMS should constitute the body through which the activity should be channeled, and that funds accruing from any campaign for the above-mentioned purposes be utilized under the direction of the Rheumatic Fever Control Committee and other appropriate committees of the MSMS in the expansion and furtherance of their programs.

  "This statement is contingent upon the understanding that a major portion of any funds raised in this state as a part of a national campaign shall remain in this state."
- Plan to secure a "Professional Associates Building" in Lansing to house executive offices of Michigan State Medical Society and similar health associations in Capitol City outlined and ordered investigated.
- Liaison Committee with Michigan Hospital Association appointed.
- The County Societies Committee of The Council was given the work of implementing information on and correction of "impractices" now existing among a small minority of the profession.
- The Council developed a statement of Policy on "Community Health Centers"

  "The MSMS recognizes the demand for better facilities to meet the medical needs of certain areas of the State.

  "Whether so-called health centers are to afford even a partial solution of the problems must depend in large measure on two considerations: one, a clear definition of the scope and nature of their functions; and two, the type of control by which their operations are to be governed.

  "Approval of health centers by The Council of the MSMS should be expected only when their purposes are consonant with the well established democratic principles of private enterprise as applied to the practice of medicine, and whenever the control of their operations is vested in private practitioners of medicine and civic and health agencies of the local community."
- Individual Councilors presented annual reports on condition of the profession in their Districts.
- Monthly Reports of General Counsel and Public Relations Counsel accepted.
- Progress report on Michigan Medical Service presented by R. L. Novy, M.D., Detroit, President.
- Progress report on Michigan Foundation for Medical and Health Education, Inc., presented by E. I. Carr, M.D., Lansing, President.
- The Counil requested the Foundation to consider ways and means of raising, establishing, and administering a student loan fund to encourage young physicians to locate in rural areas.
- Matters of mutual interest discussed with J. K. Altland, M.D., Lansing, Michigan Commissioner of Health.

SECRETARY'S ANNUAL REPORT—1947

I herewith submit the report of the Secretary for the year 1947.

Membership

The Michigan State Medical Society membership for 1947 showed a total of 4,797 members—including 66 Emeritus Members, 59 Life Members, 16 Retired Members, 5 Associate Members, 199 Military Members. The total paid membership was 4,512. The total number of members with unpaid dues for 1947 totaled 331.

The membership tabulation for the years 1946 and 1947 showing net gains, losses, unpaid dues and deaths is as follows:

Deaths During 1947

We regretfully record the deaths of the following sixty-two members during 1947.

Barry: Clarence P. Lathrop, M.D., Hastings.

Bay-Arenac-Iosco: Fred Taylor Andrews, M.D., Bay City; Roy C. Perkins, M.D., Bay City.

Berrien: John J. McDermott, M.D., Saint Joseph; A. A. Rosenberry, M.D., Benton Harbor.

Branch: Samuel Schultz, M.D., Coldwater.

Calhoun: Alpheus T. Hafford, M.D., Albion; Holton M. Lowe, M.D., Battle Creek; Elijah Van Camp, M.D., Battle Creek; Rollin C. Winslow, M.D., Battle Creek.

Eaton: Sidney B. Goff, M.D., Eaton Rapids.

Membership Record—1947

County Medical Society	*Paid 1946	*Paid 1947	*Special Membership Emer	Life	Reti	Assoc	Military 1946	Military 1947	Deaths 1946	Deaths 1947	Net Membership Close 1946	Net Membership Close 1947	1947 Gain	1947 Loss	Unpaid 1946	Unpaid 1947
Allegan	17	23	—	—	—	—	2	—	—	—	19	23	4	—	1	—
Alpena-Alcona Presque Isle	12	17	—	—	—	—	7	2	—	—	19	19	—	—	—	2
Barry	8	10	1	3	—	—	4	—	—	1	12	13	1	—	2	1
Bay-Arenac-Iosco	48	73	4	—	1	—	28	—	2	2	76	76	—	—	3	6
Berrien	48	62	—	—	—	—	12	—	—	2	60	60	—	—	—	5
Branch	18	23	—	—	—	—	8	1	1	1	26	23	—	3	—	1
Calhoun	65	101	1	2	1	—	38	4	3	4	103	105	2	—	2	9
Cass	9	10	—	—	—	—	2	—	—	—	11	10	—	1	1	—
Chippewa-Mackinac	12	18	1	—	—	—	5	—	—	—	17	19	2	—	2	5
Clinton	9	12	—	—	—	—	2	—	—	—	11	12	1	—	1	—
Delta-Schoolcraft	17	19	1	—	—	—	6	—	1	—	23	20	—	3	—	3
Dickinson-Iron	14	18	—	—	—	—	3	—	—	—	17	18	1	—	2	3
Eaton	13	18	—	—	—	—	7	—	—	1	20	17	—	3	2	5
Genesee	135	187	2	—	2	—	60	6	4	3	195	194	—	1	4	9
Gogebic	18	20	—	—	—	—	2	—	—	—	20	20	—	—	—	2
Grand Traverse Leelanau-Ben	34	41	—	—	—	—	15	6	—	—	49	47	—	2	1	7
Gratiot-Isabella-Clare	24	36	—	—	—	—	12	—	—	—	36	36	—	—	1	1
Hillsdale	13	15	—	3	—	—	5	2	1	—	18	20	2	—	5	2
Houghton-Baraga-Keweenaw	27	32	3	1	—	—	9	—	2	—	36	36	—	—	1	2
Huron	12	15	—	—	—	—	—	1	—	—	12	16	4	—	—	—
Ingham	121	154	3	2	3	—	54	7	—	3	175	166	—	9	1	17
Ionia-Montcalm	26	37	—	—	—	—	11	1	—	2	37	36	—	1	1	2
Jackson	69	103	2	—	1	—	40	6	4	1	109	111	2	—	—	6
Kalamazoo	78	119	—	4	2	—	44	4	1	4	122	125	3	—	2	4
Kent	178	258	5	11	2	—	102	26	1	4	280	298	18	—	5	12
Lapeer	10	12	3	—	—	—	4	1	—	1	14	15	1	—	—	2
Lenawee	23	43	—	—	—	—	15	—	—	—	38	43	5	—	3	5
Livingston	14	15	—	—	—	1	5	1	—	—	19	17	—	2	1	1
Luce	6	4	—	—	—	—	5	3	—	—	11	7	—	4	1	2
Macomb	30	41	—	1	—	—	14	2	—	—	44	44	—	—	1	2
Manistee	8	13	1	—	1	—	4	—	—	—	12	15	3	—	—	2
Marquette-Alger	26	39	—	1	—	—	9	—	—	1	35	39	4	—	1	2
Mason	7	12	—	—	—	—	4	—	—	—	11	12	1	—	—	—
Mecosta- Osceola-Lake	11	13	—	—	—	—	3	—	1	—	14	13	—	1	—	1
Menominee	10	12	1	—	—	—	5	1	1	—	15	14	—	1	—	3
Midland	12	15	—	—	—	—	5	1	1	—	17	16	—	1	2	1
Monroe	28	36	1	—	—	—	12	—	1	1	40	36	—	4	1	4
Muskegon	56	82	—	—	—	1	22	1	—	1	78	83	5	—	1	—
Newaygo	7	7	—	—	—	—	1	3	—	—	8	10	2	—	—	1
North Central Counties	13	14	1	—	—	—	1	—	—	2	14	13	—	1	1	1
Northern Mich.	26	29	1	—	—	—	5	3	1	—	31	33	2	—	1	3
Oakland	120	147	—	—	—	—	47	14	—	4	167	157	—	10	3	15
Oceana	7	12	—	—	—	1	3	—	—	—	10	13	3	—	1	—
Ontonagon	3	4	—	—	—	—	2	—	—	—	5	4	—	1	—	1
Ottawa	24	36	1	—	—	—	9	—	—	2	33	35	2	—	—	—
Saginaw	66	102	2	2	—	—	41	2	2	—	107	108	1	—	2	7
Saint Clair	37	50	1	2	—	—	11	5	1	3	48	55	7	—	1	1
Saint Joseph	14	23	—	—	—	—	12	1	1	—	26	24	—	2	1	1
Sanilac	10	10	—	—	—	—	3	1	—	—	13	11	—	2	—	3
Shiawassee	17	23	2	—	—	—	10	2	—	1	27	26	—	1	—	4
Tuscola	16	23	1	—	—	—	5	1	—	—	21	25	4	—	—	—
Van Buren	14	19	3	—	—	—	10	3	—	—	24	25	1	—	2	2
Washtenaw	138	163	2	—	—	—	38	16	3	1	176	80	4	—	18	43
Wayne	1529	2073	23	27	3	2	625	72	15	17	2154	2183	29	—	44	116
Wexford	15	20	—	—	—	—	8	—	—	—	23	20	—	3	1	4
Totals	3322	4513	66	59	16	5	1416	199	122	62	4738	4796	114	56	122	331

*Note: 1946 Special Memberships are included under "Paid Memberships."
1947 Special Members total 146. 1947 Membership is 58 Net over 1946.

Genesee: James A. Baird, M.D., Flint; A. Dale Kirk, M.D., Flint; James A. Rowley, M.D., Flint.

Ingham: Wilford D. Albert, M.D., Leslie; Dugald A. Galbraith, M.D., East Lansing; Francis A. Jones, Sr., M.D., Lansing.

Ionia-Montcalm: Joseph Johns, M.D., Ionia; Thomas C. Weston, M.D., Muir.

Jackson: William H. Lake, M.D., Jackson.

Kalamazoo: G. H. Caldwell, M.D., Lakewood, Ohio; William Francis Ertell, M.D., Kalamazoo; William N. Kenzie, M.D., Richland; Burt D. Walker, M. D., Kalamazoo.

Kent: George F. Lamb, M.D., Grand Rapids; M. M. Marrin, M.D., Grand Rapids; Reuben Maurits, M.D., Grand Rapids; J. R. Wiggers, M.D., Grand Rapids.

Lapeer: Frank A. Tinker, M.D., Lapeer.

Marquette-Alger: Charles N. Bottum, M.D., Marquette.

Monroe: Morley S. Vaughn, M.D., Carleton.

Muskegon: Otto M. LaCore, M.D., Muskegon.

Medical Society of North Central County: Sylvester L. Ballard, M.D., Grayling; Levi A. Harris, M.D., Gaylord.

Oakland: Alexander Borland, M.D., Pontiac; William H. Carr, M.D., Holly; John H. Gordon, M.D., Winter Haven, Florida; Bertel T. Larson, M.D., Pontiac.

Ottawa: Albert E. Stickley, M.D., Coopersville; Clarence Vincent Costello, M.D., Holland.

Saint Clair: Albert Lissell Callery, M.D., Port Huron; Gordon G. Feldman, M.D., Yale; Joseph E. Wellman, M.D., Port Huron.

Shiawassee: Alfred L. Arnold, Sr., M.D., Owosso.

Washtenaw: Jeanne Cady Solis, M.D., Ann Arbor.

Wayne: Harry M. Abrams, M.D., Detroit; John L. Asselin, M.D., Detroit; Howell L. Begle, M.D., Detroit; Peter F. Carlucci, M.D., Detroit; Joseph H. Chance, M.D., Detroit; John D. Donovan, M.D., Dearborn; Gilbert S. Field, M.D., Detroit; Samuel A. Flaherty, M.D., Detroit; William Hipp, M.D., Detroit; Simon C. Kates, M.D., Detroit; Clarence A. Kretzschmer, M.D., Detroit; Stanley J. Lassaline, M.D., Detroit; John H. Law, M.D., Detroit; William J. Lovering, M.D., Tucson, Arizona; Georgia B. Lowrie, M.D., Detroit; Phillip E. Moody, M.D., Detroit; William J. Warner, M.D., Detroit.

Financial Status

Ernst and Ernst, Certified Public Accountants, have submitted their report on the annual audit of the books of the Michigan State Medical Society. The report has been submitted to the officers of the Society and members of the Finance Committee of The Council, and is subject to the perusal of all members of the State Society.

A brief summary of the auditors' report is submitted for information of the members:

Total assets of the Society as of December 31, 1947		$180,380.47
Showing an increase for the year of	$ 21,617.54	
Included in the assets are securities valued at cost	83,125.90	
Demand deposits, cash on hand and savings deposits totaled at the end of the year	89,384.70	
Accounts receivable	7,869.87	
Totaling this, we have the assets of the Society, as stated above.		
Redemption value of these securities, as of December 31, 1947	$ 81,037.90	
Income from Membership Fees	55,805.72	
Of this amount $6,973.82 was allocated for subscriptions to The Journal.		
Interest on securities and time deposits was		$ 2,837.38
Total cash income		64,565.15
From this we may deduct expenses of administrative and general nature, together with Societies' activities, annual session expense and committee expense		56,373.56
Making a total net income of		$ 8,191.59
In the Public Relations Account there was at the beginning of the year a balance of		$ 43,614.02
Assessments collected during the year		$111,260.78
Credit from Michigan Health Council		5,000.00
Making a total in the Public Education Account		159,874.80
Total expenditures of the Public Educational Program amounted to		89,080.84
Balance of unexpended funds		$ 70,793.96

The Executive Committee in its meeting of August 13, 1947, designated $30,000.00 of the cash in savings account for the use of the Public Education Program. This amount is in addition to United States Savings Bonds, Series G, in the amount of $30,000.00, allotted for the same purpose in 1946. The aggregate amount of $60,000.00 is represented by a reserve for contingencies for the Public Education Program.

On January 1, 1947, there was in the Rheumatic Fever fund a balance of		$ 7,407.97
Grant from the Michigan Society for Crippled Children and Disabled Adults		12,218.41
Expenses during the year		14,776.60
Balance on hand December 31, 1947		4,849.78
The Journal was published at an actual cost of		$ 42,455.67
Whereas, the revenue derived from subscriptions, advertising sales and reprints totaled		54,955.54
Showing a net income of		12,499.87
Thus showing an increase in earning capacity over the year 1946, when the net income was listed as		9,404.26

A study of the financial report discloses several interesting points, among which is the fact that the Society operated last year with less than 17 per cent of its income utilized for personal services of its employes—a figure considerably below the median percentage of 41% to 49% indicated in trade association surveys.

It is further noted that the many activities of the Society, financed from the general fund, would be conducted at a loss on the basis of the present $12.00 dues. The costs of these activities are now met because the general fund is augmented by other income-producing activities, viz The Journal, the September Annual Session, and the Michigan Postgraduate Institute.

1947 Annual Session

The 1947 Annual Session was held in Grand Rapids with a total registration of 2,110.

The General Assembly type of program featuring Discussion Conferences was continued as in other recent years.

The program brought to Michigan twenty-nine essayists of national and international reputation. There were fifteen Scientific Exhibits and a Technical Exhibit in which ninety-two exhibitors participated. The registrants gave their usual very generous attention to the exhibitors. Despite the fact that no expense was spared to make the Michigan meeting as instructive and interesting as possible, and in spite of the rapidly rising costs of operating the convention, a substantial net profit accrued to the Society from the Annual Session.

Michigan Postgraduate Clinical Institute

This first scientific institute held under the sponsorship of the Michigan State Medical Society in co-operation with the University of Michigan Medical School and Department of Postgraduate Medical Education, Wayne University College of Medicine, the Michigan Founda-

tion for Medical and Health Education, Inc., and the Wayne County Medical Society was held in Detroit on March 12-14, 1947.

This Institute limited to Michigan essayists, was designed to provide a high-type scientific program, encourage Michigan physicians to prepare presentations and to publicize Michigan as a medical center.

The Institute was an outstanding success as evidenced by the fact that it produced a total registration of 1,293 with registrants present from all nearby states and Canada.

County Secretaries-Public Relations Conference

A Conference of County Secretaries and other officers and members of component county groups was held in Detroit on February 2, 1947. This all-day Conference was combined in 1947 with a Public Relations Conference. The Conference was attended by some 90 county society officers, Public Relations Committee Chairmen, representatives of the Woman's Auxiliaries and other key persons.

This Conference featured techniques of county society organization and operation, an explanation of the major activities of the State Society and information necessary for the development and maintenance of good public relations.

Committees

Fifty-two committees were engaged in the activity of planning and conducting the affairs of the State Society. Obviously time and space do not permit a detailed report of the splendid accomplishments of these groups—accomplishments achieved at the expense of many hours of personal sacrifice on the part of the personnel of the committees.

The effects of the long-range planning by most of these committees is becoming more and more apparent as the various programs continue to expand and mature.

During 1947 eighty-four committee meetings were held and practically each meeting was attended by one or both of your Secretaries. Too much commendation cannot be accorded the committee members who gave very generously of their time and effort to develop and execute constructive programs for the public welfare and to maintain the position of leadership of the Michigan State Medical Society in the field of progressive medical planning.

Rheumatic Fever Program

This Society-operated consultation and diagnostic program has grown rapidly during the past year. From a beginning of eight centers the program has now become truly state-wide. With the development of sixteen centers in Wayne County there are now in active operation or in preparation for early operation a total of thirty centers. Today, over 1,200 cases have been referred to the various centers.

The Michigan Society for Crippled Children and Disabled Adults, Inc., has generously continued its financial support for the operation of the rheumatic fever program. The program was initiated in 1946 with a $15,000 grant from the Society. This fund was replenished in 1947 for the continued operation of the project which is now attracting national attention and favorable publicity to this State. It's another First for Michigan.

The *voluntary* approach in preventive medicine can be successful, as demonstrated by the Michigan experiment in rheumatic fever control. However, the vital need for a full-time medical co-ordinator at this stage of our increased activity is indicated, to bring uniformity and inspiration to the thirty centers. Such a co-ordinator has been approved and the committee is on the lookout for the right doctor of medicine.

Committee to Study Medical Practice Act.—This committee has been most active during 1947 and is proceeding along a line which has delicate and serious implications. Your Secretary feels that its apparent aim is one of national scope, one which cannot be solved by an individual state. Close attention to the sincere efforts of this committee by the Councilors is warranted, with the view of referring the whole problem to the American Medical Association in June, through our Delegates.

Commission on Health Care.—The tentative budget of this Commission (of the House of Delegates) is $9,600 for the year 1948. This includes $6,000 for the publication of a brochure which to be effective must be printed and distributed to high school and college graduates by the end of May.

Society Activities

Some Councilor District meetings were held in 1947. These meetings, attended by various members of the administrative personnel, were designed to publicize to the Socicty membership the various activities of the State Society and to allow a discussion of any problem propounded by those present.

During 1947, a program of Organizational Seminars to be held with county societies was planned, for continuation into 1948. These seminars are designed to develop a critical discussion of the problems of the local and state medical society organization, the problems of public relations, the "impractices" of medicine, and any subject bearing upon the development and maintenance of activities necessary to the establishment of medical practice on its deserving high plane.

Courses in Medical Economics

This program of lectures on Medical Economics presented before various classes in the Medical Schools at the University of Michigan and Wayne University has been expanded both in scope and number. The presentations, made by various practicing physicians, have been very well received and over a period of time should be reflected favorably in the attitudes of our future doctors of medicine.

Distinguished Health Service Awards

During 1947 the first of these awards by the State Society were made to

Charles F. Kettering—Detroit
Emmett Richards—Alpena
Percy C. Angove—Detroit
Donald E. Johnson—Flint
Michigan Society for Crippled Children and Disabled Adults, Inc.

Contacts with Governmental Agencies

Active and friendly contacts have been maintained throughout the year with many governmental agencies at all levels—county, state, and national, including:

The Governor of Michigan
Michigan Crippled Children Commission
Michigan State Board of Registration in Medicine
U. S. Senators and Congressmen from Michigan
Federal-State Hospital and Construction Administrations and Advisory Committees
State Health Commissioner
Michigan Prison Commission

Subjects discussed included immunization campaign during February, 1948; continuation of third and fourth year residencies in hospitals, with licensure; proposed unification of all health agencies; better health and medical conditions in prison; construction of hospitals in rural areas of Michigan; publicity for Michigan's "Greatest Public Trust"—Michigan Medical Service.

One governmental project saw its demise in 1947—the unfortunate EMIC. This is an encouraging sign.

Contacts with non-Governmental Agencies

During 1947 the Society continued its active participation and interest in the sponsorship of major organizations—viz; Michigan Hospital Service, Michigan Medical Service, the Michigan Foundation for Medical and Health Education, Inc., the dental, nursing, pharmaceutical and hospital associations, the Michigan Health Council.

Comments: (a) The Michigan Hospital Service-Mercy Hospitals problems—upon which a Special Committee of The Council is working and acting as intermediary (at the specific request of the Michigan Hospital Association and Michigan Hospital Service) is not as yet solved. We have great apprehension that this condition, if not eradicated soon, will seriously interfere with the effectiveness and operation of our own Michigan Medical Service.

(b) The Michigan Hospital Association requested that MSMS appoint a liaison committee to work with it on the matter of more adequate nursing. If such a liaison committee is appointed, its scope of activity should go far beyond the study of the nursing problem, as many matters of joint concern deserve the attention of such a group.

(c) The impossibility of finding more office space for the MSMS Executive Offices in Lansing is now apparent. Either the Society must purchase its own home—or go in with other professional groups having headquarters in the Capital City to stimulate the erection of a "Professional Associates Building," financed by outside interests from whom the associations would lease the premises for long terms.

Public Relations

The Public Relations activity of the Michigan State Medical Society has become so varied and far reaching in both its work and its effect that this report can scarcely do more than indicate its scope. It should be noted at once, however, that there is general recognition throughout the United States that the MSMS Public Relations Program ranks first among all state medical society public relations efforts.

Basically, our Public Relations Program is built on *investigation* and good judgment, *action* to resolve problems, and the *dissemination* of information. It is built with the thought constantly in mind that the MSMS Public Relations effort is an "all-society" proposition and is not limited solely to the activities of the Public Relation Committee members. We search out public attitudes, opinions, and needs. This is done informally by constant contact with the lay public through both the members of our Society and its lay representatives, and formally by a Health Survey being conducted by a Social Research Service. Upon the information received, the Society, through its officers, councilmen, and committees, judges what is to be done. Thousands of hours have been spent individually and in committee meetings to make these determinations. Appropriate action is taken, whether it be to counsel an erring member or to initiate a state-wide movement. Finally, the various communication media constantly carry a comprehensive report of our activity both to the public and to other interested organizations.

An outline of some of the sub-titles will serve to show the extent of our activity:

I. *Investigation*
   - A. Reports of individual members and lay representatives
   - B. Michigan Health Survey by Social Research Service of Michigan State College under direction of MSMS Health Survey Advisory Committee.

II. *Action*
   - A. Report to the House of Delegates and membership on Public Relations impractices of members.
   - B. Michigan Rural Health Conference, a joint effort of the MSMS and thirty other agencies to explore and solve rural health needs.

The Conference indicated the need for more general practitioners and problems affecting medical care in rural areas. It was noted that attempts are being made both state-wide and nationally to correct these situations, both by alterations in the education of doctors, the building of hospitals in rural areas, and the development of scholarship funds to educate doctors who will settle in rural areas. The Conference recommended that a committee investigate, plan and organize a students' medical loan or scholarship fund. It is possible that through additional contributions to the Michigan Foundation for Medical and Health Education, sufficient funds might be raised so that from the income on these funds such loans or scholarships can be made available. The conference also recommended:

   - (a) That a Second Rural Health Conference be held in 1948.
   - (b) That a committee be set up to plan and assist in the organization of local health councils in rural areas.
   - (c) That a licensing law for hospitals be passed.
   - (d) That a specific program for improving rural health be established under direction of a committee of the Rural Health Conference.
   - C. Secretaries and Public Relations Conference, February 2, 1947, to co-ordinate and stimulate our public relations efforts
   - D. Informal conference February 8, 1947, of state and county medical society Public Relations Counsels to organize concerted national effort
   - E. Continuous exchange of information with other state and county medical societies

Our radio program "Tell Me, Doctor," our Health News Column, our newspaper advertisements, our planning and public relations know-how have been made available and are being used by other state and county medical societies.

F. Legislative effort both in Lansing and in Washington

III. *Education*

A. Radio: Three state-wide programs—two fifteen-minute weekly programs and one five-minute daily program carry our message constantly to millions of listeners. Special radio programs, such as the seven special programs at the Annual Session, reached additional thousands.

B. Newspapers

1. Newspaper advertisements placed in 128 newspapers reached 80 per cent of Michigan's population, or approximately 4 million persons 18 times during 1947.
2. The Health News Column placed weekly in 250 newspapers in Michigan reaches additional millions of persons.
3. News releases and news coverage by newspaper reporters, columnists, and editors, both in and out of the state, have constantly carried our information (over 2,000 clippings were obtained on the MSMS Annual Session).
4. Magazines: *The Michigan Farmer, Medical Economics,* State Medical Journals, *Look Magazine,* and others have carried articles on Michigan's medical efforts.

NOTE: The irreducible minimum of bad publicity has been counter-balanced by the great preponderance of good publicity.

C. Publications

1. The publication of the "Medical Plan for Michigan," an over-all "bible" listing the various activities of the MSMS for reference use by members and the laity has been prepared and is nearing completion for publishing.
2. A report on the Michigan Rural Health Conference is nearing the publication state.
3. Booklets and printed material by the thousand were disseminated to high school and college students.
4. Public Relations Bulletins and news articles in THE JOURNAL have kept the membership informed and stimulated on P.R. activity.
5. The Brochure on Medical Associates has been prepared.
6. "Your Child is Safer in Michigan," "Leading in Learning" and "Invest in Health" were among the pamphlets prepared for closely related health organizations.

D. Public Speaking

1. Literally hundreds of speeches have been made to the membership, to other medical organizations, and to lay groups (colleges, fraternal, civic, service and veterans organizations) on both medical scientific and medical socio-economic subjects by officer, members, and authorized representatives.

E. Cinema

1. Initial plans for a 10-minute film for display in 400 commercial theaters has been culminated.

F. Organizational Contact

1. Close integration with other organizations in the health field has been accomplished.
2. Activity toward the reactivation of the Michigan Health Council has been carried on.
3. The Woman's Auxiliary has been stimulated and their efforts have been of definite assistance.
4. Work in connection with the schools and school administrations has been carried on.
5. Awards have been prepared and given to deserving laity who have contributed to the cause of health.

G. Personal Contact

1. Close association with newspapermen and radio broadcasters has been made in their own community.
2. Continuous contact with various legislators has been made—intensively during the Regular Session of the legislature and extensively since that time.
3. Hundreds of contacts with other individuals, who can be of assistance to us and with whom we can carry on co-operative effort, have been maintained.

H. Schools

1. Lectures have been given to high school and college classes and close co-operation and information given to assist their public speaking classes and students in general.
2. Contests in schools have been stimulated through local societies.
3. A series of 16 sex hygiene 15-minute programs for instruction in the schools is being prepared and nearing completion.

I. Correspondence

1. The correspondence has increased tremendously as a result of the activity noted above making it a factor in itself as a public relations communication media.

J. Planning: A great deal of planning for 1948 has been done, promising an even more superlative program in 1948 made possible by the financial assistance of members through the $25.00 assessment passed by the House of Delegates.

Conclusion.—All of these activities have been carried out under the Policies of The Council, the leadership of the Public Relations Committee, the co-operation of the Executive Office and the assistance of the Executive Secretary, Wm. J. Burns, the activity of the Public Relations office under the direction of High W. Brenneman, Public Relations Counsel, and the services of Wallace-Lindeman, Inc., of Grand Rapids. This activity could not have been effected except for the excellent co-operation of the members of the MSMS and its Auxiliary, both financially and by individual self-sacrificing activity, the newspaper reporters and editors, radio stations and personnel, schools and school administrators, a mass of lay health organizations, and thousands of individuals who have given of their time, assistance and good advice. We can conclude that we have pioneered the field of modern medical public relations: that our exploration of the problems and the development of techniques for meeting the problems has been successfully accomplished; that our progress has been noteworthy with the promise of even greater success during the crucial years to come.

Secretary's Letters

As part of the Society's general educational program for individual members and component county societies there were issued during the year eight Secretary's Letters—six to county secretaries and keymen and two to all members of the Michigan State Medical Society. In like manner, seventeen Legislative Bulletins were mailed during the 1947 session of the Legislature, five to all members and twelve to the MSMS legislative keymen.

Office Personnel

During 1947 various replacements and additions to the personnel in the Executive Offices have been made. The resignation of Assistant Executive Secretary, Mr. J. Lynn Leet, necessitated a replacement in the person of Mr. Henry Hopp, Jr. An increase in the tempo of society activities made necessary the acquiring of additional space in the Olds Tower and the employment of several new stenographers. The crowded and scattered condition of our Executive Offices still works an ever-increasing hardship on the whole office personnel and is not conducive to good morale and the greatest efficiency.

Recommendations

As a result of a careful analysis of the Society's activities, its financial condition, the prospective economic conditions and the attitude of the public toward medical organization, I respectfully submit the following recommendations for your consideration:

1. The continuation of a progressive modern public relations program utilizing to a greater extent the individual doctor of medicine in his home community.

2. A study of the annual dues of the Society in the light of a possible change in our national economy—and with a view to maintaining our present program of activities. Such a study to determine, if necessary, a recommendation to the House of Delegates on this subject. An increase in dues would result, of course, in a lowering or possible elimination eventually of the present assessment.

3. The stimulation of Organizational Seminars in every county society with a view to eliminating the apparent increase of the "impractices of medicine" on the part of individual members.

4. The development of programs designed to place organized medicine in a more prominent position in local public health and civic activities.

5. A more concrete and definite study to provide as soon as possible adequate executive offices.

6. The continuation in 1948 of the excellent public relations project of sending a number of MSMS representatives to the Michigan Congressional Meeting in Washington, D. C., in the early spring.

7. The creation of a "Michigan Foremost Family Physician Award."

8. The assumption by the Public Education Department, MSMS, of the necessary activities of the Michigan Health Council—if the Council remains dormant and its officers are agreeable to this proposed arrangement.

9. The development of a vigorous membership drive by every county medical society of this state, stimulated by the State Society, to the end that all reputable doctors of medicine become associated with organized medicine (including the 331 who were dropped from membership for non-payment of their 1947 dues).

10. Further aid to the Woman's Auxiliary in developing a more efficient organization and financial subsidy, if necessary, for the employment of part or full time personnel.

Your Secretary desires to express to the members of The Council his sincere appreciation for the very fine co-operation and encouragement they have given him during 1947.

To the Executive Office personnel, and to Mr. Brenneman and his staff, I wish to express a personal appreciation of their loyalty, willing application to their tasks and their many constructive suggestions. As usual, Mr. Burns has been most generous and understanding in his splendid co-operation—his wise counsel and his dynamic inspiration.

To all who have aided so generously in the discharge of the duties of this office, your Secretary is most grateful.

Respectfully submitted,

L. Fernald Foster, M.D.
Secretary

EDITOR'S ANNUAL REPORT—1947

The Journal of the Michigan State Medical Society has completed another year, the forty-sixth. We started the year about one month late, The Journal being delivered to our members and subscribers about the fifteenth of the month following the date of the issue. This was a situation that grew up during the war with labor and material shortages. There was also the use of much more color, especially in the advertising, which made several extra runs through the presses, and more labor in the binding room, all taking time and all contributing to the lateness of The Journal. During the year just passed we have on two occasions had The Journal delivered to our subscribers during the month of the date line. We are in hopes that this coming year we may be still more prompt, and approach the regular issue date of the fifteenth of the month.

The size of The Journal, that is the number of pages, has been slightly reduced this year, partly due to the new advertising policy of using only Council-accepted advertisements, which has cost us many pages of advertising. It has also been due to a predetermined plan to cut the number of pages devoted to certain features. We have devoted less space to some of the socio-economic material, have concentrated on the more important, with the idea of giving our readers an accurate and sufficient accounting to keep them posted on affairs medical from a national angle. In 1944 we published 1134 pages; in 1945, 1428; in 1946, 1682; and in 1947 there were 1476 pages.

During this year we have cut down the pages of political medicine, war medicine, medical public relations, rehabilitation for veterans, and medical service plans, but we believe we have covered the field rather fully. That material has continued to appear in the front advertising pages, and we have had no adverse criticism on that account. All of our contemporary Journals are using that material in the text of The Journal. We still prefer our own make-up.

We have published original articles from ninety-six authors, of whom one has appeared three times (as co-authors), and four have appeared twice. We have had mostly papers on scientific medicine, and we believe an unusual number have really been outstanding articles; at least, our readers have told us so. We have used most of the papers presented at the Annual Session, and the Postgraduate Clinical Institute gave us material for over two issues. We are planning on benefiting again this

year by the presentation of leadership articles which will be forthcoming from our own members.

Forty-five editorials have been prepared and published. We believe, as we always have, that it is the duty of an editor to keep his readers informed of the progress of economic and sociologic thought, the trends of the profession, and point out the things that will in the seeable future demand foresight and forethought. We have tried to do this, and to anticipate as far as possible the needs for action.

Thirty-eight deaths have been recorded. Seventy-six book reviews have been prepared and published. We have also published two groups of abstracts, the proceedings of the Detroit Physiological Society, which has given us some very interesting articles, and the abstracts of papers presented at the Postgraduate Clinical Institute, which were not given us to use in their entirety.

We are again proud to submit this report of a year's work. We believe it has given our subscribers, as it has us, a measure of profit and satisfaction. Our Society has made much real progress during the year, and we have attempted to preserve the record.

Respectfully submitted,

WILFRID HAUGHEY, M.D.

TRUSTEE'S REPORT—1947

Year ended December 31, 1947

Trust balance at January 1, 1947			$ 3,691.90
Additions:			
Interest on securities	$115.56		
Gain on redemption of bonds	625.00		
Return premium on fidelity bond	18.63	$759.19	
Deductions:			
Premium on fidelity bond	$ 12.50		
Service fee on bonds redeemed	.75	13.25	745.94
Trust balance at December 31, 1947			$ 4,437.84
Trust balance represented by:			
Demand deposit—Michigan National Bank			$ 3,235.34
Securities—at cost			1,202.50
TOTAL			$ 4,437.84
(1 Grand Rapids Affiliated Corp. 5% valued at $960.00 on 12-31-47 1 Southern Pacific 4½% valued at $950.00 on 12-31-47)			
NOTE: If the book value as of December 31, last, of the bonds is added to the total the net worth of the Trustees fund is $707.50 more, or a total of			$ 5,145.34
To which is added the value of the recent cashed coupon of the Grand Rapids Affiliated Corp. belonging to last year's account			25.00
Total worth of Trustee fund on 1-22-48			$ 5,170.34

Your Trustee was authorized to dispose of bonds in the Trustee fund at his discretion. At present we have but two left in the portfolio which are of a high interest return. These will be carefully watched and disposed of at an opportune moment.

Respectfully submitted,

WILLIAM A. HYLAND, M.D.
Trustee

TREASURER'S ANNUAL REPORT—1947

The changes in bonds owned during the year were as follows:

Balance at January 1, 1947		$ 82,860.15
ADDITIONS		
Purchase of United States Treasury Bonds, 2½%, maturing December 15, 1972-67	$ 8,243.75	
Increase in redemption value of United States Savings Bonds, acquired in prior years	447.00	8,690.75
		$91,550.90
DEDUCTIONS		
Bonds redeemed and matured:		
United Light and Power Company, 5½%, maturing April 1, 1959	$ 925.00	
United States Savings Bonds, Series C, maturing July 1, 1947	7,500.00	8,425.00
Balance at December 31, 1947		$ 83,125.90
Represented by:		
Bonds held for general purposes		$ 53,125.90
Bonds designated for the Michigan State Medical Society Public Education Program		30,000.00
Balance at December 31, 1947		$ 83,125.90
INCOME		
Earnings on Bonds at Jan. 1, 1947 to Jan. 1, 1948		$ 1,646.39
Increase in value of United Light and Power Bond, disposed of in 1947		75.00
Cash Balance in Bank, at Jan. 1, 1947		2,584.37
Aggregate receipts for Bonds sold in excess of aggregate amount paid to purchase Bonds in 1947		181.25
TOTAL		$ 4,487.01
EXPENSE		
Additional cost of United States Treasury Bond, due to accrued interest at time of purchase	$ 39.89	
Bank Service Charge	3.44	
Service cost on current account and check book	3.65	$ 46.98
CASH IN BANK		$ 4,440.03
MARKET, OR REDEMPTION PRICE OF ALL BONDS, as of Jan. 1, 1948		$ 81,037.90
TOTAL		$ 85,477.93

Respectfully submitted,

A. S. BRUNK, M.D.

SECURITIES IN POSSESSION OF TREASURER—JANUARY 1, 1948

	Interest Rate	Maturity	Interest Paid to	Principal Amount	Cost	Market or Redemption Prices Jan. 1-1947
Bonds held for General Purposes:						
Canadian Pacific Railway Company	4 %	Perpetual	July 1-1947	$ 2,000.00	$ 1,855.00	$ 1,900.00
Detroit Edison Company	3½	Sept. 1-1966	Sept. 1-1947	2,000.00	2,187.50	2,162.50
Grand Rapids Affiliated Corporation	5	Oct. 1-1955	Oct. 1-1947	1,000.00	920.00	960.00
New York Central Railroad Company	4	Feb. 1-1998	Aug. 1-1947	2,000.00	1,173.75	1,260.00
Southern Pacific Company	4½	Mar. 1-1977	Sept. 1-1947	1,000.00	850.00	950.00
United States Savings Bond, Series G	2½	Jan. 1-1956	Dec. 1-1947	5,000.00	5,000.00	4,740.00
United States Savings Bonds, Series G	2½	Feb. 1-1957	Aug. 1-1947	17,600.00	17,600.00	16,825.00
United States Savings Bond, Series G	2½	June 1-1957	Dec. 1-1947	5,000.00	5,000.00	4,780.00
United States Savings Bond, Series G	2½	Dec. 1-1957	Dec. 1-1947	1,000.00	1,000.00	962.00
United States Savings Bonds, Series G	2½	May 1-1958	Nov. 1-1947	5,000.00	5,000.00	4,845.00
United States Savings Bonds, Series D	Note A	Apr. 1-1949		1,300.00	1,222.00	1,222.00
United States Savings Bonds, Series F	Note A	May 1-1953		2,500.00	2,087.50	2,087.50
United States Savings Bonds, Series F	Note A	July 1-1953		700.00	575.40	575.40
United States Savings Bonds, Series F	Note A	Sept. 1-1953		500.00	411.00	411.00
United States Treasury Bonds—Note B	2½	Dec. 15-1972-67	Dec. 15-1947	8,000.00	8,243.75	8,017.50
Bonds held for the Public Education Program:						
United States Savings Bonds, Series G	2½	Aug. 1-1958	Aug. 1-1947	30,000.00	30,000.00	29,340.00
			TOTAL	$84,600.00	$83,125.90	$81.037.90

NOTE A—Bonds purchased on discount basis. Do not bear interest.

MICHIGAN MEDICAL SOCIETY BUDGET ESTIMATES—1948

GENERAL FUND

INCOME		
4400 Members @ $12 Dues		$ 52,800
Less Allocation to JOURNAL @ $1.50		6,600
		$ 46,200
Interest Income		1,500
Miscellaneous Income		100
TOTAL INCOME		$ 47,800
From Reserves		7,620
		$ 55,420
APPROPRIATIONS		
Administrative and General		
Administrative Salaries		$ 7,000
Salaries—Office and General		6,560
General Counsel		3,000
General Counsel Expense		700
Office Rent and Light		1,500
Printing, Stationery and Supplies		1,500
Postage		500
Insurance and Fidelity Bonds		3,660
Auditing		700
New Equipment and Repairs		1,000
Telephone and Telegraph		2,000
Payroll Social Security Taxes		200
Unemployment Compensation Taxes		750
Miscellaneous General Expense		300
		$ 29,370
Society Activity		
Council Expense		$ 5,000
House of Delegates Expense		600
Delegates to AMA		700
General Society Travel		1,500
Officer's Travel		1,500
National Conference on Medical Service		500
Secretary's Letter		700
Woman's Auxiliary—Annual Meeting		300
Fifty Year Club Expense		200
Sundry Society Expense		500
		$ 11,500
Committee Expense		
Legislative Committee		$ 3,000
Distribution of Medical Care		50
Post-Graduate Medical Education		5,000
Preventive Medicine		100
Cancer Committee		5,000
Child Welfare		50
Heart and Degenerative Diseases		100
Industrial Health Care		50
Maternal Health		50
Mental Hygiene		100
Scientific Radio		50
Venereal Disease Control		150
Tuberculosis Control		50
Ethics		50
Scientific Work		250
Sundry Other Committees		500
		$ 14,550
GRAND TOTAL (Expenses)		$ 55,420
GAIN OR LOSS	Loss	$ 7,620

THE JOURNAL

INCOME		
Subscriptions (4400 @ $1.50)		$ 6,600
Other Subscriptions		200
Advertising Sales		40,600
Reprint Sales and Cuts		2,500
TOTAL INCOME		$ 49,900
EXPENSES		
Salaries		$ 8,200
Editor's Expense		1,800
Printing and Mailing		29,000
Reprint and Cut Expense		1,875
Discount and Commission on Advertising Sales		8,625
Miscellaneous JOURNAL Expense		400
Total Expenses		$ 49,900

PUBLIC EDUCATION ACCOUNT

Reserve 12/31/47 (Including $30,000 in Government Bonds and $30,000 in Savings)	$ 70.793.96
Estimated Income from Assessment (4400 @ $25.00)	110,000.00
TOTAL	$180,793.96

Expenses

Salaries		$ 10,140.00
Extra Assistants		4,000.00
Rent and Light		600.00
Telephone and Telegraph		900.00
Printing, Stationery and Supplies		1,200.00
Postage		900.00
New Equipment		520.00
Travel		2,200.00
Public Relations and Secretary Conference		3,000.00
Purchase of Pamphlets		5,000.00
National Conference on Medical Service		200.00
Committee Meetings		1,000.00
Newspapers		12,000.00
Radio		15,500.00
School Program and Libraries		1,000.00
Display		1,000.00
Cinema		15,000.00
Awards and Miscellaneous Expenses		714.21
Other Activities		1,600.00
Rural Medical Health Survey		4,000.00
Commission on Health Care		
Salary	$ 1,200.00	
Office Expenses	300.00	
Brochures	6,000.00	7,500.00
Total Estimated Expenses		$ 87,974.21
Reserve (Including $30,000 in Government Bonds and $30,000 in Savings)		92,819.75
		$180,793.96

RHEUMATIC FEVER CONTROL COMMITTEE

INCOME		
Balance as of Sept. 30, 1947		$ 6,400.00
Contribution from Michigan Society for Crippled Children (to bring fund up to original $15,000)		8,600.00
Additional contribution from M.S.C.C.D.A. needed for activities listed below		9,690.00
TOTAL REQUIRED INCOME		$ 24,690.00
EXPENSES		
Central Office (Lansing)		
Travel		$ 1,500.00
Equipment and Supplies		510.00
Printing and Stationery		200.00
Payroll Taxes		300.00
Committee Meetings		300.00
Publications		300.00
Miscellaneous Expense		100.00
		$ 3,210.00
EXPENSES OF CENTERS		
Alpena		$ 768.20
Ann Arbor		768.20
Bay City		1,536.40
Grand Rapids		3,380.08
Jackson		737.47
Kalamazoo		1,536.40
Lansing		1,536.40
Marquette		2,765.52
Pontiac		768.20
Port Huron		768.20
Saginaw		768.20
Traverse City		1,536.40
Detroit and Wayne County (16 Centers)		4,610.33
TOTAL EXPENSES (Center)		$ 21,480.00
TOTAL EXPENSES		$ 24,960.00
Balance of unexpended funds 12/31/47		

BUDGET ESTIMATES, CANCER CONTROL COMMITTEE, 1948

INCOME		
Contributions from Michigan State Medical Society and from American Cancer Society, Michigan Div., and from other sources		$ 5,000.00 22,640.00
TOTAL INCOME		$ 27,640.00
EXPENSES		
Secretary's Salary	$ 6,000.00	
Secretary's Expenses	1,500.00	
Stenographer's Salary	1,200.00	
Social Security Taxes	100.00	
Office Supplies	400.00	
Telephone and Telegraph	240.00	
Committee Expense, Travel, meetings, etc.	2,000.00	
Printing Reports of Two State Surveys	3,500.00	
Printing Michigan Cancer Program Booklet	1,200.00	
Preparation and publication of professional educational material	10,000.00	
Distribution of same	1,500.00	
TOTAL EXPENSES		$ 27,640.00

REPORT OF ERNST & ERNST

We have examined the balance sheet of Michigan State Medical Society as of December 31, 1947, and the statements of income and expense and surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

In our opinion, the accompanying balance sheet and related statements of income and expense present fairly the position of Michigan State Medical Society at December 31, 1947, and its income and expenses for the year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

ERNST & ERNST,
Certified Public Accountants

January 12, 1948

BALANCE SHEET—December 31, 1947

ASSETS

Cash		
Demand deposits	$ 45,560.52	
Office cash fund	7.75	
Savings deposits—Note A	43,816.43	$ 89,384.70
Accounts Receivable		
Advertising	$ 4,183.62	
Space at 1948 Postgraduate Clinical Institute	3,786.25	
	$ 7,969.87	
Less reserve	100.00	7,869.87
Securities (aggregate market or redemption price $81.037.90)		
United States Government Bonds—Note A	$ 76,139.65	
Other bonds	6,986.25	83,125.90
		$180,380.47

LIABILITIES

Accounts Payable		
Current expenses and miscellaneous liabilities	$ 13,863.35	
Pay roll taxes	327.53	$ 14,190.88
Unearned Income		
Dues for the year 1948	$ 930.00	
Sales of space for 1948 Postgraduate Clinical Institute	6,140.00	
Dues of members in armed services applicable to a future year	2,400.00	9,470.00
Reserves—for unexpended funds received for special purposes		
Public Education Program:		
For contingencies—Note A	$ 60,000.00	
For current expenses	10,793.96	$ 70,793.96
Rheumatic Fever Control Program	4,849.78	
R. S. Sykes Lectures	500.00	76,143.74
Surplus		
Balance at January 1, 1947	$ 72,384.26	
Net income for the year 1947	8,191.59	80,575.85
		$180,380.47

Note A—Savings deposits in the amount of $30,000.00 and United States Government bonds, in the amount of $30,000.00, have been designated as applicable to the contingency Reserve for the Public Education Program.

INCOME AND EXPENSE STATEMENT
Year ended December 31, 1947

Income		
Membership fees	$ 53,405.72	
Income transferred from dues of military members deferred in prior years	2,400.00	
	$ 55,805.72	
Less portion allocated to income of "The Journal" for subscriptions	6,973.82	$ 48,831.90
Income from "The Journal"		12,499.37
Interest:		
On securities	$ 2,471.00	
On time deposits	366.38	2,837.38
Gain on disposal of bonds		95.00
Miscellaneous income		301.00
TOTAL INCOME		$64.565.15
Expenses		
Administrative and general	$ 28,280.16	
Society activities	11,502.17	
Annual and special sessions	3,843.37	
Committee expenses	12,747.86	56,373.56
NET INCOME		$ 8,191.59

PUBLIC EDUCATION PROGRAM
Year ended December 31, 1947

Balance of unexpired funds at January 1, 1947, as reflected in reserve	$ 43,614.02
Cancellation of liability for contribution to Michigan Health Council	5,000.00
Net income for the year, as shown below	22,179.94
Balance of unexpended funds at December 31, 1947, as reflected in reserve	$ 70,793.96

INCOME AND EXPENSE

Income from assessment of members	$111,260.78
Expenses:	
Salaries	$ 11,000.18
Radio programs	21,236.80
Newspaper programs	35,671.61
Display advertising	983.55
Purchase of pamphlets	1,878.06
Rural health conference	1,677.39
Rural medical health survey	5,000.00
Immunization program	31.84
Rent and lights	197.25
Telephone and telegraph	962.41
Printing, stationery, and supplies	1,118.00
Postage	1,531.27
Office equipment and repairs	703.64
Travel expenses	1,946.45
Secretary's conferences	2,657.10
Conference of presidents	50.00
Committe meetings	783.64
Legislative expense	41.26
Commission on health care, misc. expense	487.49
Miscellaneous	1,122.90
TOTAL EXPENSES	$ 89,080.84
NET INCOME	$ 22,179.94

RHEUMATIC FEVER CONTROL PROGRAM
Year ended December 31, 1947

Balance of unexpended funds at January 1, 1947, as reflected in reserve	$ 7,407.97	
Grants from The Michigan Society for Crippled Children and Disabled Adults, Inc.	12,218.41	$19,626.38
Less expenses for the year, as shown below		14,776.60
Balance of unexpended funds at December 31, 1947, as reflected in reserve		$ 4,849.78

EXPENSES

Expenses of central office:		
Salaries	$1,401.25	
Equipment and supplies	80.18	
Postage	1,485.00	
Committee meetings	491.67	
Pay roll taxes	58.21	
Miscellaneous	102.21	$ 3,618.52
Expenses of local consultation and diagnostic centers—advances and expenses:		
Ann Arbor	$ 250.00	
Bay City	1,000.00	
Grand Rapids	2,500.00	
Kalamazoo	1,822.38	
Lansing	585.70	
Marquette	1,750.00	
Pontiac	250.00	
Saginaw	500.00	
Traverse City	1,000.00	
Wayne County	1,500.00	11,158.08
TOTAL EXPENSES		$ 14,776.60

Comments

The Michigan State Medical Society was organized on September 17, 1910, under the laws of the State of Michigan as a corporation not for pecuniary profit. The charter was extended on November 10, 1941, for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes the Society publishes THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

The balance sheet at December 31, 1947, is summarized as follows:

ASSETS	
Cash	$ 89,384.70
Accounts receivable	7,869.87
Securities	83,125.90
	$180,380.47
LIABILITIES	
Accounts payable	$ 14,190.88
Unearned income	9,470.00
Reserves for unexpended funds received for special purposes	76,143.74
Surplus	$ 80,575.85
	$180,380.47

A summary of the income and expense statement for the year ended December 31, 1947, is presented as follows:

Income	
Membership fees	$ 48,831.90
Income from "The Journal"	12,499.87
Interest	2,837.38
Gain on redemption of bond	95.00
Miscellaneous	301.00
TOTAL INCOME	$ 64,565.15
Expenses	
Administrative and general	$ 28,280.16
Society activities	11,502.17
Annual and special sessions	3,843.37
Committee expenses	12,747.86
TOTAL EXPENSES	$ 56,373.56
NET INCOME	$ 8,191.59

Schedules included hereinafter show in greater detail the income from THE JOURNAL and the expenses of the Society in comparison with the respective budgets. THE JOURNAL, as in prior years, has been allotted $1.50 from each membership fee.

Accounts receivable for advertising were analyzed as to period of charge and are shown as follows:

	December 31, 1947	
PERIOD OF CHARGE, 1947	Amount	Percent
October, November, and December	$3,935.62	94.07%
July, August, and September	120.00	2.87%
January to June, inclusive	128.00	3.06%
TOTAL	$4,183.62	100.00%

Our examination of accounts receivable as of December 31, 1947, included tests of the balances by communication with selected debtors. It is our opinion that the reserve of $100.00 is sufficient for losses in collection of the accounts.

The changes in bonds owned during the year were as follows:

Balance at January 1, 1947		$ 82,860.15
ADDITIONS		
Purchase of United States Treasury Bonds, 2½%, maturing December 15, 1972-67	$ 8,243.75	
Increase in redemption value of United States Savings Bonds acquired in prior years	447.00	8,690.75
		$ 91,550.90
DEDUCTIONS		
Bonds redeemed and matured:		
United Light and Power Company, 5½%, maturing April 1, 1959	$ 925.00	
United States Savings Bonds, Series C, maturing July 1, 1947	7,500.00	8,425.00
Balance at December 31, 1947		$ 83,125.90
Represented by:		
Bonds held for general purposes		$ 53,125.90
Bonds designated for the Michigan State Medical Society Public Education Program		30,000.00
Balance at December 31, 1947		$ 83,125.90

Bonds owned at December 31, 1947, have been stated at cost, adjusted for increases in redemption value of United States Savings Bonds. We inspected the bonds held by the Society and accounted for the income from all bonds for the period. At December 31, 1947, the aggregate cost of the bonds held by the Society was $2,088.00 in excess of the aggregate market or redemption price. Details of the bonds are shown in a schedule in this report.

The executive committee in its meeting of August 13, 1947, designated $30,000.00 of the cash in savings accounts for the use of the Public Education Program. This amount is in addition to United States Savings Bonds, Series G, in the amount of $30,000.00, allotted for the same purpose in 1946. The aggregate amount of $60,000.00 is represented by a reserve for contingencies for the Public Education Program.

The Society has continued its policy of waiving payment of dues by members in military or naval service and, in the event the dues were paid for the year of induction, to allow free membership for a designated period following discharge. The balance of $4,800.00 classified as unearned dues at December 31, 1946, was reduced to $2,400.00 during the year 1947 by transferring $2,400.00 to income. The balance of $2,400.00 in this account at December 31, 1947, is sufficient to provide for dues of members now in, or recently discharged from the Armed Services who entered service as currently paid-up members of the Society.

A statement of income and expenses of the Public Education Program conducted by the Society is included in this report. The unexpended balance of funds assessed for this purpose has been reflected as a reserve in the accompanying balance sheet.

This report also includes a statement of the expenses of the Committee on Rheumatic Fever Control. A contribution of $12,218.41 was received during the year from The Michigan Society for Crippled Children and Disabled Adults to be used in the furtherance of the Society's rheumatic fever program. The unexpended balance of the contributions made by The Michigan Society for Crippled Children and Disabled Adults at December 31, 1947, has been reflected as a reserve in the accompanying balance sheet.

The Society received a contribution from R. S. Sykes, D.D.S., of $500.00 during the year, which has been reserved for the cost of lectures at future Annual Ses-

sions of the Society and at the Michigan Postgraduate Clinical Institute.

EXPENSES

Year Ended December 31, 1947

	Actual
Administrative and general:	
Salaries—administrative	$ 6,000.00
Salaries—office	5,768.80
General council	3,199.38
Office rent and light	1,459.50
Printing, stationery, and supplies	2,762.09
Postage	2,051.09
Insurance and fidelity	1,598.05
Audit	695.00
New equipment and repairs	933.64
Telephone and telegraph	2,193.44
Pay roll taxes	1,073.13
Miscellaneous	486.04
	$ 28,280.16
Society activities:	
Council expense	$ 5,331.55
Delegates to American Medical Association	1,402.49
General society travel expenses	1,533.73
Officers' travel expenses	1,785.78
Secretary's letter	511.35
Women's auxiliary—annual session	300.00
Sundry expense	637.27
	$ 11,502.17
Annual and special sessions:	
Allocation of salaries	$ 5,650.71
Other expenses	18,172.66
	$ 23,823.37
Less sales of display space	$ 19,980.00
	$ 3,843.37
Committee expenses:	
Legislative	$ 1,564.85
Postgraduate medical education	4,266.00
Preventative medicine	54.95
Cancer	5,006.15
Heart and degenerative diseases	112.14
Maternal health and child	43.40
Mental hygiene	63.86
Scientific radio	35.77
Venereal disease	142.63
Tuberculosis	16.95
Scientific work	229.84
Sundry other committees	1,211.32
TOTAL	$ 56,373.56

THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Year ended December 31, 1947

Income	
Subscriptions from members	$ 6,973.82
Other subscriptions	286.50
Advertising sales	44,917.38
Reprint sales	2,777.84
	$ 54,955.54
Expenses	
Salaries	$ 6,996.43
Editor's expenses	1,200.00
Printing and mailing	22,917.72
Cost of reprints and cuts	1,788.55
Discounts and commission on advertising sales	9,174.11
Miscellaneous	378.86
	$ 42,455.67
NET INCOME	$ 12,499.87

CASH—December 31, 1947

Demand deposits:		
Michigan National Bank, Lansing—general account	$ 41,120.49	
The Detroit Bank—Treasurer's account	4,440.03	$ 45,560.52
Office change fund		7.75
Savings deposits—Note A:		
Michigan National Bank, Lansing	$ 8,500.93	
American State Savings Bank, Lansing	5,037.50	
Bank of Lansing, Lansing	5,037.50	
Bay City Bank, Bay City	5,068.93	
Peoples Commercial and Savings Bank, Bay City	5,073.17	
The Detroit Bank, Detroit	5,032.67	
Manufacturers National Bank of Detroit, Detroit	5,032.36	
Wabeek State Bank of Detroit, Detroit	5,033.37	43,816.43
TOTAL		$ 89,384.70

Note A—Savings deposits in the amount of $30,000.00 have been designated as a part of a contingency fund for the Public Education program.

SECURITIES—December 31, 1947

	Interest Rate	Maturity	Interest Paid to	Principal Amount	Cost	Market or Redemption Prices 12-31-47	Market or Redemption Prices 12-31-46	Income For Year
Bonds held for general purposes:								
Canadian Pacific Railway Company	4 %	Perpetual	July 1-1947	$ 2,000.00	$ 1,855.00	$ 1,900.00	$ 2,100.00	$ 80.00
Detroit Edison Company	3½%	Sept. 1-1966	Sept. 1-1947	2,000.00	2,187.50	2,162.50	2,175.00	70.00
Grand Rapids Affiliated Corporation	5 %	Oct. 1-1955	Oct. 1-1947	1,000.00	920.00	960.00	950.00	50.00
New York Central Railroad Company	4 %	Feb. 1-1998	Aug. 1-1947	2,000.00	1,173.75	1,260.00	1,515.00	80.00
Southern Pacific Company	4½%	Mar. 1-1977	Sept. 1-1947	1,000.00	850.00	950.00	1,012.50	45.00
United States Savings Bond, Series G	2½%	Jan. 1-1956	Dec. 1-1947	5,000.00	5,000.00	4,740.00	4,810.00	125.00
United States Savings Bonds, Series G	2½%	Feb. 1-1957	Aug. 1-1947	17,600.00	17,600.00	16,825.00	17,054.40	440.00
United States Savings Bond, Series G	2½%	June 1-1957	Dec. 1-1947	5,000.00	5,000.00	4,780.00	4,845.00	125.00
United States Savings Bond, Series G	2½%	Dec. 1-1957	Dec. 1-1947	1,000.00	1,000.00	962.00	978.00	25.00
United States Savings Bonds, Series G	2½%	May 1-1958	Nov. 1-1947	5,000.00	5,000.00	4,845.00	4,940.00	125.00
United States Savings Bonds, Series D	Note A	Apr. 1-1949		1,300.00	1,222.00	1,222.00	1,170.00	52.00
United States Savings Bonds, Series F	Note A	May 1-1953		2,500.00	2,087.50	2,087.50	2,022.50	65.00
United States Savings Bonds, Series F	Note A	July 1-1953		700.00	575.40	575.40	557.90	17.50
United States Savings Bonds, Series F	Note A	Sept. 1-1953	Dec. 15-1947	8,000.00	8,243.75	8,017.50		60.11
United States Treasury Bonds—Note B	2½%	Dec. 15-1972-67		500.00	411.00	411.00	398.50	12.50
Bonds called and redeemed in 1947:								
United Light and Power Company								48.89
United States Savings Bonds, Series C								300.00
Bonds held for the Public Education Program:								
United States Savings Bonds, Series G	2½%	Aug. 1-1958	Aug. 1-1947	30,000.00	30,000.00	29,340.00	29,640.00	750.00
			TOTAL	$ 84,600.00	$ 83,125.90	$ 81,037.90		$ 2,471.00

Note A—Certain United States Savings Bonds do not bear interest but are purchased on a discount basis. Their redemption value increases progressively until maturity at which time they are redeemable at principal amount. The amounts shown as cost of these bonds on this schedule are the redemption values at December 31, 1947, and the amount of income shown for the bonds is the increase of such value over that at December 31, 1946.

Note B—These bonds were purchased in 1947.

ERNST & ERNST REPORT ON TRUSTEE'S ACCOUNT—1947

In connection with our examination of the balance sheet of the Michigan State Medical Society as of December 31, 1947, we have examined certain records maintained by Dr. William A. Hyland relative to a trust of which he is Trustee for the Michigan State Medical Society.

The following statements and schedule relative to the trust for the year ended December 31, 1947, are included herein:

Statement of cash receipts and disbursements
Statement of trust balance
Securities

Cash on deposit on December 31, 1947, was confirmed by correspondence with the depository bank. We inspected the securities held in trust. Interest on securities for the year was accounted for. We examined data on file with respect to bonds owned which were redeemed during the year. Cash disbursements for the year were found to be supported by cancelled checks and other data on file.

ERNST & ERNST,
Certified Public Accountants

January 12, 1948

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

Year ended December 31, 1947

Cash on deposit on December 31, 1946			$ 1,114.40
Receipts:			
Interest on bonds	$ 115.56		
Proceeds from redemption of bonds	2,000.00		
Return premium on fidelity bond	18.63	$ 2,134.19	
Disbursements:			
Premium on fidelity bond	$ 12.50		
Service fee on bonds redeemed	.75	13.25	2,120.94
Cash on deposit on December 31, 1947			$ 3,235.34

STATEMENT OF TRUST BALANCE

Year ended December 31, 1947

Trust balance on January 1, 1947			$ 3,691.90
Additions:			
Interest on securities	$ 115.56		
Gain on redemption of bonds	625.00		
Return premium on fidelity bond	18.63	$ 759.19	
Deductions:			
Premium on fidelity bond	$ 12.50		
Service fee on bonds redeemed	.75	13.25	745.94
Trust balance on December 31, 1947			$ 4,437.84
Trust balance represented by:			
Demand deposit—Michigan National Bank			$ 3,235.34
Securities—at cost			1,202.50
TOTAL			$ 4,437.84

SECURITIES
William A. Hyland, Trustee
December 31, 1947

	Interest Rate	Maturity	Interest Paid to	Principal Amount	Cost	QUOTED MARKET PRICES 12-31-46	12-31-47	Increase Decrease*	Interest Income For Year 1947
Grand Rapids Affiliated Corporation	5 %	Oct. 1-1955	Apr. 1-1947	$1,000.00	$ 730.00	$ 960.00	$ 950.00	$10.00	$ 25.00-B
Southern Pacific Company	4½	Mar. 1-1977	Sept. 1-1947	1,000.00	472.50	950.00	1,012.50	62.50*	45.00
Bonds disposed of in 1947:									
New England Gas and Electric Association—Note A	5								45.56
			TOTAL	$2,000.00	$1,202.50	$1,910.00	$1,962.50	$52.50*	$115.56

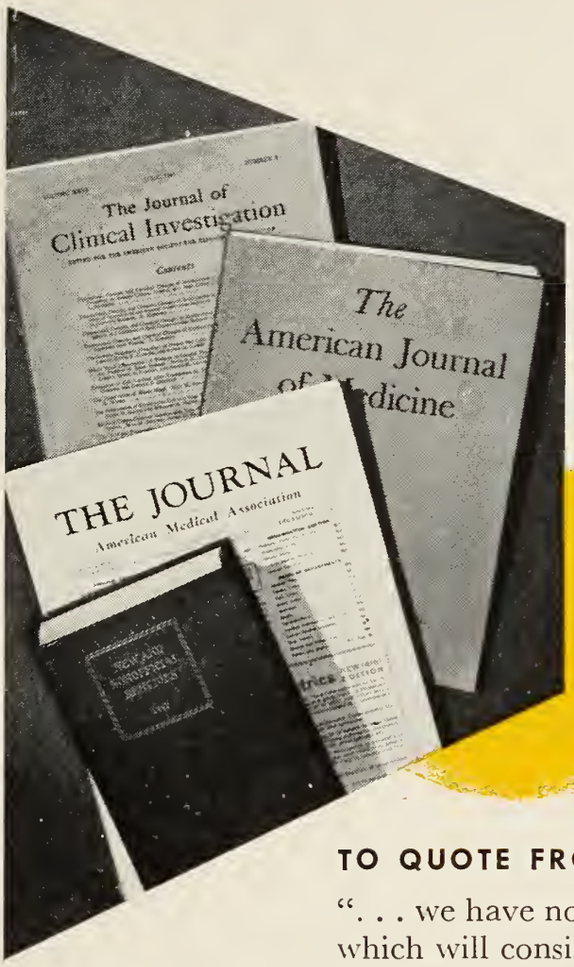
Note A—These bonds were called for redemption on April 15, 1947, at principal amount and accrued interest.

Note B—The interest coupon due October 1, 1947, had not been cashed on December 31, 1947.

JOURNAL DEBUNKS SEVEN DAY "CURE" FOR CHRONIC ALCOHOLISM

"A simple cure for chronic alcoholism, seven day, seven week, or even seven year, does not exist," according to an editorial in the November 1 issue of *The Journal of the American Medical Association.*

"Since the publication of an article, 'Seven Day Cure for Alcoholism,' in *Magazine Digest,*" the editorial says, "*The Journal* has been receiving inquiries from both physicians and the public requesting further information and confirmation of the efficacy of the treatment proposed. . . . The treatment described is a withdrawal method, using slowly decreasing doses of alcohol intravenously over a period of six or seven days. The patients treated by the authors were those with acute alcoholic dementia, hallucinosis and delirium tremens. These patients were treated equally as successfully by the intravenous method as others have been who took decreasing, doses by mouth along with other adjuvant treatment, but no more so. . . . The authors admit that this method does not produce a permanent cure of chronic alcoholism. The patients may well return to the abuse of alcohol, as they frequently do following other types of withdrawal treatment. The personality factors that cause maladjustment to environment must be determined and controlled. . . . Aside from its usefulness in withdrawal treatment, the technic seems about as illogical as the sugar treatment of diabetes or the morphine treatment of the opium habit."



Increasing recommendation for **gold therapy** in active rheumatoid arthritis

TO QUOTE FROM RECENT AUTHORITATIVE SOURCES:

". . . we have not found any therapy other than gold therapy which will consistently and in a high percentage of cases change the course of the disease."[1]

"Gold therapy at present seems to be the only drug which shows promise of checking the activity of rheumatoid arthritis; . . . ."[2]

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"The high incidence of reactions attributable to the formerly employed larger doses . . . has been largely obviated by the use of more conservative doses."[3] Moreover, "therapeutic results are quite as good with smaller doses...."[4]

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CAUTION

Gold Sodium Thiosulfate must be used with extreme caution, especially in the presence of tuberculosis and diseases of the liver and kidneys.

1. *Combined Staff Clinics of the College of Physicians and Surgeons, Columbia University: Am. J. Med. 1:675 (Dec.) 1946.*
2. *Comroe, B. I.: J.A.M.A. 128:848 (July 21) 1945.*
3. *Council of Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. B. Lippincott Company, 1947, p. 477.*
4. *Freyberg, R. H.; Block, W. D., and Levy, S.: J. Clin. Investigation 20:401 (July) 1941.*

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Postgraduate Continuation Courses

WAYNE UNIVERSITY COLLEGE OF MEDICINE

March 15-June 12, 1948

These courses are open to all qualified persons. Veterans who are not Residents in a Detroit Hospital should make arrangements for tuition and books, as provided by the GI Bill, with Mr. Arthur Johnson, Veterans Administrator at Wayne University, 5063 Cass Avenue. *This must be completed before you register.*

Registration for these courses can be made in the office of Post-Graduate Medical Education at the College of Medicine, 512 St. Antoine *before March 12.*

Title of Course	*Place*	*Day*	*Hours*	*Fee*
Anatomy				
Surgical Anatomy (Second half)	College of Medicine	Tuesday	3-5	$35.00
Regional Anatomy Trunk (Begins March 10)	College of Medicine	Wednesday	1-5	$50.00
Extremities and Back (Begins March 11)		Thursday	2-5	$50.00
Head and Neck (Begins March 12)		Friday	1-5	$50.00
Problems in Neurology	College of Medicine	Thursday	3-5	$35.00
Bacteriology				
Immunology and Virology	College of Medicine	Wednesday	1-5	$35.00
Parasitology	College of Medicine	Friday	1-5	$35.00
Physiology				
Blood	College of Medicine	Tuesday Friday	4-5 3-5	$35.00
Physiological Chemistry				
Seminar	College of Medicine	Wednesday	4-5	$15.00
Survey of Medical Chem. (Begins March 11)	College of Medicine	Thursday	5-6	$15.00
Intermediary Metabolism (Begins March 26)	College of Medicine	Friday	4-5	$15.00
Nutrition & Metabolism	College of Medicine	Monday Wednesday Friday	11-12	$35.00
Pathology				
Beginning Hematology	College of Medicine	Monday	1-5	$50.00
Advanced Hematology *(Prerequisite—Begin. Hematol.)*	College of Medicine (5)	Friday	1-5	$50.00
Gynecologic Pathology	College of Medicine (35)	Wednesday	1-5	$50.00
Pathology of Children's Diseases	College of Medicine	Friday	1-5	$50.00
Anesthesiology				
Anesthesia Theory and Practice	Receiving Hospital	Thursday	4-5	$15.00
Dermatology				
Seminar	Receiving Hospital	Wednesday	10-11:30	$15.00
Conference on Venereal Diseases	Social Hygiene Cl.	Thursday	4-5:30	$15.00
Internal Medicine				
Medical Pathologic Conf.	Receiving Hospital	Saturday	11-12	$15.00
	Wayne County General	Thursday	11-12	$15.00
Diagnostic Conference	Wayne County General	Tuesday	4-5	$15.00
Gastroenterology Clinic Hematology Clinic	Receiving Hospital	Wednesday	1-2	$15.00
Allergy Clinic & Conf.	Receiving Hospital	Tuesday	8-11	$25.00
Medical X-Ray Conference	Receiving Hospital (10)	Tuesday	11-12	$15.00
	Wayne County General	Friday	1-2	$15.00
Physical Medicine	Grace Hospital	Thursday	1-5	$35.00
Psychiatry				
Child Guidance Clinic	Children's Center	Tuesday	8-12	$25.00
Clinical Psychiatric Sem.	Wayne County General	Wed.	2:30-4:30	$15.00
Orthopsychiatry and Pediatrics	To be arranged			$15.00
Neurologic Conference	Receiving Hospital	Saturday	9-11	$15.00
	Wayne County General	Tuesday	10-11	$15.00
Psychosomatic Conference	Receiving Hospital	Thursday	2-4	$15.00
	Wayne County General	Monday	1-2	$15.00
Surgery				
Seminar	College of Medicine (20)	Thursday	4-5	$15.00

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Michigan's Department of Health

J. K. Altland, M.D., Commissioner

YEAR END SUMMARY

Michigan had the lowest death rate in 1947 of any year in its history, according to a year end summary on the state of Michigan's health.

On the basis of the first ten months' figures, it is estimated that the death rate in the state will decrease to 9.3 per 1,000 population, as compared with the rate of 9.6 in 1946 and the previous record low of 9.52 in 1942.

The largest number of births in history and the lowest infant and maternal death rates were recorded in 1947. Judging from the first ten months, 1947's bumper crop of babies, about 160,000, will exceed the 1946 record of 138,572 babies by 22,000 or more. It appears that the 1947 infant death rate will drop to 31.6 per 1,000 live births in comparison with the 1946 rate of 32.8, and that the 1947 maternal death rate will drop to 1.07 per 1,000 live births compared with 1.18 in 1946. Michigan's maternal death rate of 5.55 in 1943 was lower than that of any previous year and it has dropped each year since.

Leading Causes of Death Change

Judging from the first nine months, the ten leading causes of death will undergo only two changes from last year. Premature births which last year moved from ninth to eighth place move up to seventh place this year, replacing tuberculosis. Congenital malformations this year came into tenth position replacing hardening of the arteries. Both these changes are thought to be due to the increased number of babies born in the 1946 and 1947 periods.

Heart disease, as usual, continues to lead all other causes of death, with cancer in second place. During the first nine months of 1947 heart disease caused 13,631 deaths in comparison with 13,258 during the same period in 1946. Cancer killed 5,987 persons during the nine-month period in comparison with 5,680 in the same period of 1946. Apoplexy was in third place for the nine-month period with 3,875 deaths; followed by accidents, with 2,836; inflammation of the kidney, 1,918; pneumonia, 1,521; premature births, 1,455; tuberculosis, 1,259; diabetes, 1,224; and congenital malformations, 758.

Most Disease Incidence Low

All major communicable diseases with the exception of measles and whooping cough remained below the seven year average.

The rise in whooping cough started in 1945 and is still continuing. Measles remained low until September when it began to assume epidemic proportions in the southwest corner of the state. Cases are appearing in adjoining counties and there is likelihood that 1948 will be an epidemic year.

Typhoid fever remained low. Only 69 cases were reported in the first eleven months compared with the 83 cases in the same period in 1946. Of this year's cases, 19 were due to a localized outbreak caused by contamination of a community well by a typhoid carrier.

Only 623 cases of poliomyelitis were reported in the first eleven months compared with 1,019 in the same period in 1946. The disease in 1947 was mild in character. Less than a third of the reported cases had demonstrable paralysis during their illness and in this group the vast majority recovered completely.

Malaria showed an expected decrease. All malaria cases were members of the armed forces who had contracted the disease, usually in the Italian and South Pacific theaters. Most of our forces have returned from these areas. There were 143 cases in the first eleven months compared with 1,251 in the same period in 1946.

There were no amebic dysentery outbreaks during 1947, but there was a small bacillary dysentery outbreak of 41 cases in a state college.

Only one case of smallpox was reported in the first eleven months of 1947 compared to three in the same period in 1946.

The year 1947 saw a reversal of the upward trend which has characterized venereal disease since 1940. During the year two field workers were employed to assist in case finding in counties not covered by a full-time health department and in organized counties having high incidence.

More than 289,000 free seventy millimeter chest x-rays for tuberclosis were made during the year. A fifth mobile x-ray unit was added. Greater emphasis is being placed on community-wide case finding programs in tuberculosis control.

Advisory service in matters relating to social and economic problems of the tuberculous patient was made available for the first time to tuberculosis hospitals, sanatoria and local health departments.

Laboratories Busy

For the 26th year the Department distributed biologic products without charge to physicians and health officers in the state. Doses distributed totalled 2,535,513 and included diphtheria toxoid, smallpox vaccine, whooping cough vaccine, tetanus toxoid and various other products to prevent or control disease. These biologics are produced in the Michigan Department of Health Laboratories in Lansing.

For the first time the Laboratories produced for statewide distribution a serum for treatment of influenzal type B meningitis.

The Laboratories offer physicians free diagnostic tests. During the year 910,536 diagnostic tests were performed in the Laboratories, including the branch laboratories at Grand Rapids, Houghton and Powers. For the control of water, milk and sewage 128,193 examinations were made.

(Continued on Page 334)

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Martin H. Hoffmann, M. D.
Medical Superintendent

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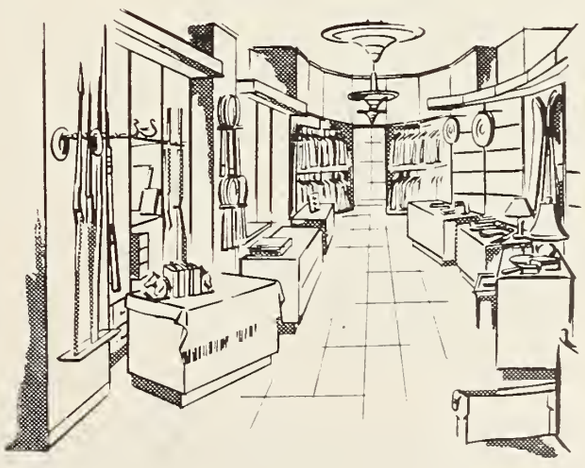
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OUR SPORTS SHOP
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YEAR END SUMMARY

(Continued from Page 332)

Michigan's blood plasma program continued in 76 co-operating counties where 156 hospital-distributing centers made plasma available to any physician without charge. Use of blood plasma in 1946-47 increased 43 per cent over 1945-46.

New Vision Program

A children's vision conservation program was launched during the year to assist local communities in prevention, detection and correction of eye defects among school children. Since the beginning of the school year the vision of over 10,000 children has been tested.

The hearing of more than 40,000 school children in 727 schools was tested revealing that one in every thirty children tested has some hearing loss.

Department nutritionists continued efforts to improve the food habits of the people and co-operated closely with state and local groups in food conservation programs.

Dental Program Advances

New methods of control of dental caries are being tested.

The mass control program in Grand Rapids where fluorine is being added to the public water supply completed its third year in January, 1948. It is too early to make a definite report on the long-range program, but satisfactory progress is being made. A 60 per cent reduction in dental caries showed results if the treatment is successful.

The "painting" a sodium fluoride solution on the teeth of children passed from the experimental stage to being recommended for state-wide use by practicing dentists. A 40 per cent reduction in dental caries among children is expected.

A fact-finding clinic in Sturgis disclosed that only one-third the time is required to keep a child's mouth in a healthy dental condition as is required to place it in such a condition, and that many cases of imperfect tooth occlusion and facial deformity can be corrected very early and in less time than previously supposed. A similar clinic in Isabella county opened January 5, 1948.

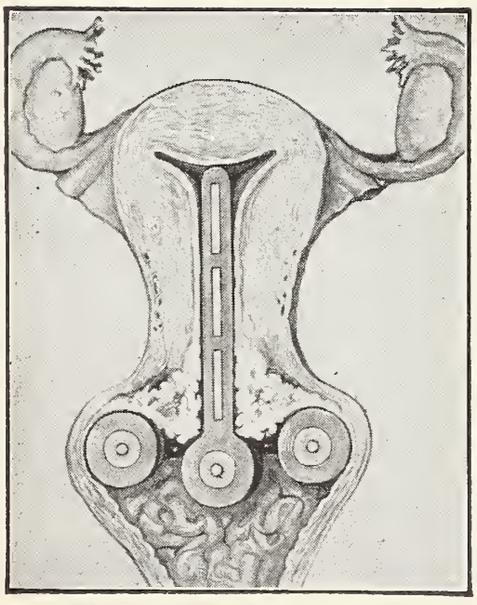
Safe Water Provided

Years of careful attention to the location and construction of municipal water supplies were justified last spring when, in spite of flood waters which inundated numerous sources of muncipal supply, and which necessitated sand-bagging to keep pumps operating at several pumping stations, there was no failure and no contaminated water was delivered.

Aided Industry

Industry spent more than $3,000,000 in complying with the Department's recommendations to improve industrial working conditions and control industrial health hazards during 1947.

IMPROVE YOUR RESULTS IN CANCER OF THE CERVIX



CONSISTENTLY high percentages of 5-year cures in Carcinoma of the Cervix are reported by institutions employing the French technique illustrated here. Ametal rubber applicators encase the heavy primary screens and provide ideal secondary filtration to protect the vaginal mucosa. Radium or Radon applicators for the treatment of Carcinoma of the Cervix and provided with Ametal filtration are available exclusively through us. Inquire and order by mail, or preferably by telegraph or telephone reversing charges. Deliveries are made to your office or hospital for use at the hour you may specify.

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New Units Formed

The formation of a new county health department in Macomb county, the combination of the Lansing-Ingham county units, and Delta and Menominee county units, and the combination of Luce, Mackinac and Chippewa county units brought to 45 the number of full-time county and district health departments serving the state. They cover 71 counties. Approximately 92 per cent of Michigan's population now receives the benefit of full-time local health service.

Nurses Shortage

The acute shortage of nurses continued throughout the year. At the beginning of the year 161 fewer public health nurses were employed by health agencies than in 1941, a total of 815 as compared with 976. There were 270 public health nursing vacancies.

Vital Records Preserved

To protect and preserve Michigan's oldest birth records which date back to 1867, microfilming of these records was started during this year. Birth records for the years 1867 through 1905 are being transferred onto film.

Approximately 11 million vital records—births, marriages and divorces—are on file in the vault of the Michigan Department of Health.

World Fame Continues

During the year the Department assisted in training more Inter-American students in health and sanitation than any other agency in the country; was visited by foreign public health personnel from 21 countries representing all areas of the globe; and continued as a training center for public health students from the leading universities of this nation. These facts indicate the high standing of the Department in national and international public health circles.

SALMONELLA STUDY ADVANCES

The Salmonella Study being conducted by the Department of Health and the United States Public Health Service to determine the relationship of certain human illnesses to diseases in farm, pet and wild animals and birds, is ready to operate in high gear.

Special laboratory facilities have been arranged and two bacteriologists have arrived and are being trained for the work. A special 27-foot mobile bacteriology laboratory trailer hauled by a jeep is available for use in fact-finding trips into areas hit by food poisonings or where suspected Salmonella infections are prevalent.

Dr. Arthur H. Wolff is in charge of the project which is being carried on under the supervision of Dr. F. S. Leeder, Director of the Bureau of Disease Control, with the assistance of the Laboratories.

PRACTICAL NURSES SURVEY PLANNED

Plans are being made by the Michigan Practical Nurses Association for a survey of all practical nursing power in the state, as an aid in relieving the critical general nursing shortage.

All practical nurses, nurses aides, attendants, orderlies, and undergraduate nurses as well as non-graduate nurs-



"An excellent simple presumptive test for routine use in the diagnosis of diabetes."[1]

CLINITEST

THE TABLET *NO-HEATING* METHOD FOR DETECTION OF URINE-SUGAR

SIMPLE TECHNIC—"My experience with Clinitest has convinced me beyond a shadow of a doubt that they are *the simplest* from the technical standpoint . . ."[2]

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Clinitest—simple, speedy, compact, convenient—is distributed through regular drug and medical supply channels.

1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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Guaiacol	**0.10 Gm.**
Eucalyptol	**0.08 Gm.**
Iodoform	**0.02 Gm.**
Camphor	**0.05 Gm.**

in sesame oil.

Indications:

Sinusitis, Bronchitis, upper respiratory infections (rhinitis—otitis) Guacamphol promotes drainage by its liquefacient action —reduces inflammation by its antiseptic action—and produces prompt symptomatic relief by its sedation effects.

Dosage:

The average dose is 2 cc. daily—by intramuscular injections—until improvement occurs. Thereafter, 2 or 3 injections weekly as needed.

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Exclusive distributor for Metro ampules.

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ing help in doctors offices and homes for the convalescent or aged are asked to fill out cards.

The survey is being compiled to show the work of practical nurses during this nursing emergency and to show what power is available in case of epidemic or other catastrophe, according to Mrs. Irene Humes, president of the Practical Nurses Association. The association hopes to interest more unemployed women in the 18 to 50 age bracket in practical nursing and to be able to give training for these people who wish it.

Survey cards may be had by writing Mrs. Hume, in care of the Michigan Nursing Center Association, 750 East Main Street, Lansing, Michigan.

WARN OF OZONE MACHINES

Garage owners throughout the state have been warned not to buy or use ozone generating machines which are being peddled by salesmen who contend that they will eliminate carbon monoxide fumes.

The machines have no value in eliminating carbon monoxide and they are dangerous in themselves. Salesmen tell the garage operators that the ozone generated by the machines will combine with the carbon monoxide to form harmless carbon dioxide, but the amount of ozone required to eliminate even a minor carbon monoxide hazard is dangerous. In addition, the use of the machine gives the garage operators a false sense of security so that they do not take ordinary precautions against the deadly fumes. The satisfactory way to eliminate carbon monoxide from a running motor in a garage is to attach a device directly to the automobile exhaust which will carry the fumes outside the building.

CERTIFICATES ISSUED

The State Health Department now issues upon request a Certificate of Registration for births and adoptions in accordance with Act Number 343, Public Acts of 1947. This short form certificate contains only the name of the person, sex, color, date and place of birth and the date on which the certificate was recorded. The fee for this certificate of registration is 25 cents. This type of certificate is used for legitimate and illegitimate births and adoption records.

RECEIVES FELLOWSHIP

Dr. William Wesley Ferguson, Co-ordinating Bacteriologist, and Chairman of the Michigan Department of Health Laboratories Research Committee has been granted a $1,500 fellowship by the Commonwealth Fund of New York. He is to leave New York March 26 to go to the Danish Serum Institute in Copenhagen for two months study in the classification of the coliform and paracolon group of organisms.

BIOLOGICS FURNISHED TWENTY-SIX YEARS

The two and a half million doses of biologic and other products which the Michigan Department of Health produced and distributed free to physicians in the 1947 fight to control and prevent disease are a far cry from the small beginning twenty-six years ago.

The first biologic products distributed by the Depart-

ment were to fight diphtheria. Michigan had one of the highest diphtheria death rates of any place in the world. Twenty-six out of every 100,000 people in the state died of diphtheria each year in 1920.

The late Dr. C. C. Young, then Director of the Bureau of Laboratories, told Governor Alex Grosbeck that the diphtheria death rate could be cut in half in ten years if the laboratories were enabled to furnish physicians, free of charge, the biologic products to prevent and treat the disease. The 1921 legislature provided for the free distribution and the service began in January, 1922. By last year the death rate from diphtheria had been cut from twenty-six to less than one per 100,000 population.

In the interim since 1922, products distributed have come to include blood plasma as well as vaccines, toxoids, anti-toxins and serums for the diagnosis, prevention or treatment of many diseases. During the fiscal year 1946-47 the Michigan Department of Health Laboratories manufactured 2,535,513 doses of biologic and other products which were distributed free to the physicians of the state. These included products to fight diphtheria, smallpox, whooping cough, typhoid fever, tetanus, rabies, scarlet fever, influenzal and meningococcic meningitis, tuberculosis, syphilis, gonorrheal opthalmia, and other diseases.

Before these biologics were available (in 1920), communicable diseases caused 34.6 of every 100 deaths in the state; in 1946 they accounted for only 9.2 deaths of every 100.

In 1947, only two infectious contagious diseases were among the ten major causes of death in the state, pneumonia and tuberculosis. Michigan's pneumonia death rate was cut in half during the days of serum therapy, before the sulfa and penicillin era, with the assistance of serums made in the Laboratories. Today, one of the major projects of the Laboratories is directed toward discovery of an antibiotic which will kill the tubercle bacillus germ.

COMMUNICABLE DISEASES DOWN 40,000 CASES

The number of communicable disease cases reported to the Michigan Department of Health dropped from 140,067 in 1946 to 100,773 in 1947.

The decrease is largely attributable to the drop from 42,261 to 9,583 in measles cases.

While measles led all other major communicable diseases in 1946, syphilis, gonorrhea and whooping cough led, in that order, in 1947.

The incidence of the major communicable diseases for the two years follow:

Disease	*1946*	*1947*
Syphilis	18,051	15,276
Gonorrhea	12,527	10,989
Whooping cough	8,116	10,483
Measles	42,261	9,583
Tuberculosis	5,548	6,470
Scarlet Fever	5,977	4,819
Poliomyelitis	1,091	646
Undulant fever	135	303
Malaria	1,305	148
Meningococcic meningitis	185	113
Salmonella infections	83	111
Typhoid fever	85	77
Influenzal meningitis	33	43
Smallpox	3	1



a SPENCER for intervertebral disc

In both conservative and surgical treatment of intervertebral disc, the application of a back support is usually indicated.*

We invite the physician's investigation of Spencer as adjunct to treatment. Each Spencer is *individually designed, cut, and made* for each patient—after a description of the patient's body and posture has been recorded and detailed measurements taken. Thus, individual support requirements are accurately met. The Spencer Spinal Support shown above was individually designed for this man. Note outside pelvic binder for added pelvic stability.

For a dealer in Spencer Supports look in telephone book for "Spencer corsetiere" or "Spencer Support Shop," or write direct to us.

*Barr, Joseph S., *Ruptured Intervertebral Disc and Sciatic Pain*, Jr. Bone and Joint Surg., 29: 429-437 (April) 1947.

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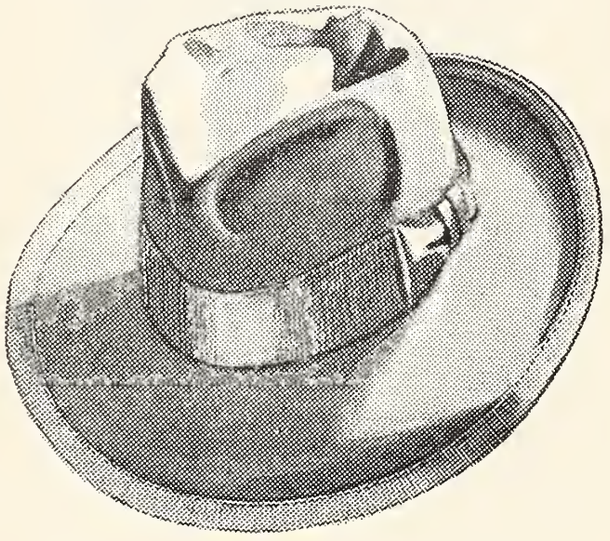
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INCIDENCE OF COMMUNICABLE DISEASE*

Disease	*December 1947*	*December 1946*
Diphtheria	12	31
Gonorrhea	800	911
Lobar pneumonia	70	74
Measles	2679	251
Meningococcic meningitis	5	13
Pertussis	621	893
Poliomyelitis	21	72
Scarlet fever	412	729
Syphilis	1285	1336
Tuberculosis	650	498
Typhoid fever	7	2
Undulant fever	39	9
Smallpox	0	0

Disease	*January 1948*	*January 1947*
Diphtheria	20	41
Gonorrhea	772	983
Lobar Pneumonia	64	102
Measles	3007	204
Meningococcic meningitis	4	5
Pertussis	482	922
Poliomyelitis	2	14
Scarlet fever	569	570
Syphilis	1123	1277
Tuberculosis	464	385
Typhoid fever	1	1
Undulant fever	17	8
Smallpox	0	0

*These figures are provisional, and subject to correction.

STUDY IN DEPARTMENT

F. C. Ke, M.D., of the Chinese National Health Administration, Shanghai, studied in the Department during January. His primary interest was in Rh typing and other laboratory procedures.

Julio Augusto Sierra, M.D., of Guatemala visited the Department from November 10 to January 14, under the auspices of the Division of Health and Sanitation of the Institute of Inter-American Affairs. He studied the manufacture of pertussis vaccine in the Laboratories.





EARLY AND LATE ECTOPIC PREGNANCY

(Continued from Page 288)

tin in the peripheral blood. We hope this will stimulate others to employ and further perfect this line of approach. The successful management of late ectopic or abdominal pregnancy depends upon accurate diagnosis as aided by roentgen studies, the decision that laparotomy is indicated, proper preparation of the patient for operation, and the treatment of the placenta. The latter is of much importance, and it is our rule to leave the placenta undisturbed and without drainage or marsupialization, unless there is obvious infection or it is clear that the placenta can be easily separated and extracted without serious blood loss.

Say you saw it in the Journal of the Michigan State Medical Society

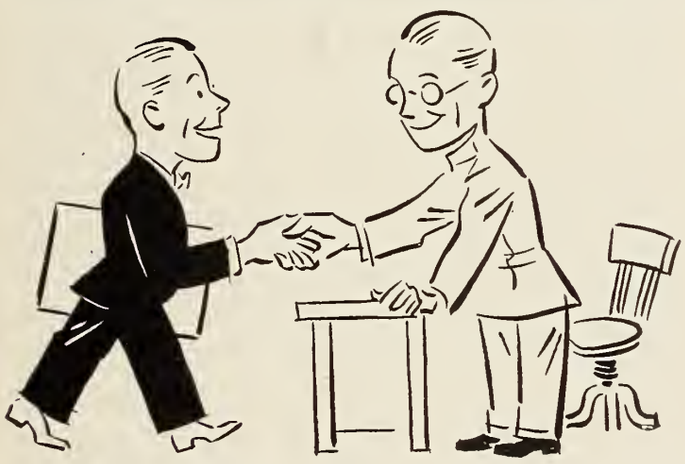
Woman's Auxiliary

THE MICHIGAN TUBERCULOSIS SPEAKING PROJECT

Mrs. Leonard M. Folkers
East Lansing, Michigan

Three thousand five hundred and thirty-seven high school students brought tuberculosis to the attention of an estimated audience of twenty thousand people during the early winter months just past. Developing this interest was the project of the Woman's Auxiliary to the Michigan State Medical Society, co-operating with the Michigan Tuberculosis Association, in the sixth annual TB Speaking Project throughout the state. At least eighty-one communities became more tuberculosis conscious, for that number of schools participated. The number of student homes alerted to tuberculosis numbered in the thousands. The topics "You and I versus Tuberculosis," "For the Protection of the Public Health" and "From Oxen to Airplanes" reached innumerable individuals in class rooms, community audiences and over the radio as they contributed their messages to the total health program of school, community and state.

The Medical Auxiliary chairman in every county promoted the project in her area in three ways. She personally contacted school authorities and explained that the purpose of the project is education—the most effective weapon known against TB—and urged that it be incorporated into the course of study by using the topics and reference materials as class assignments. Her second task was to act as judge of local scripts when requested by the schools. By arranging community audiences of parents, service clubs, church groups, women's clubs and radio she performed her third service. These audiences, before whom the three local winners in each community gave their talks, ranged in size from thirteen hundred in Port Huron, where two hundred students participated, to six in a very small town where three students participated. It is interesting that in seven communities in the state the talks were heard by men's clubs: Lions and Rotary in Hancock, Rotary in Houghton, Exchange in Davison, Rotary in Imlay City, Future Farmers of America in Lake City, Lions in Flushing, and the Chamber of Commerce in Reed City. It is of even greater interest that sixteen local broadcasting stations throughout the state gave time to present the winning



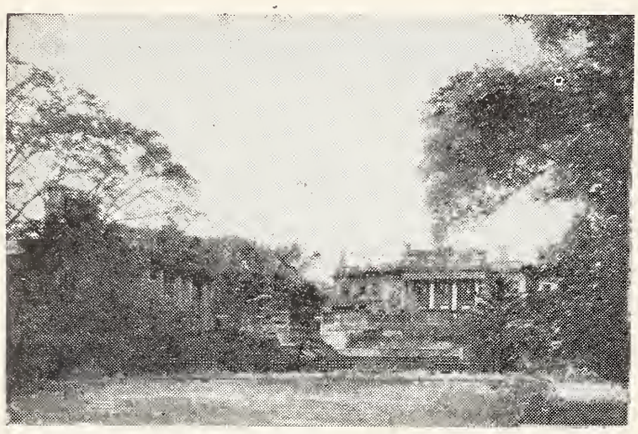
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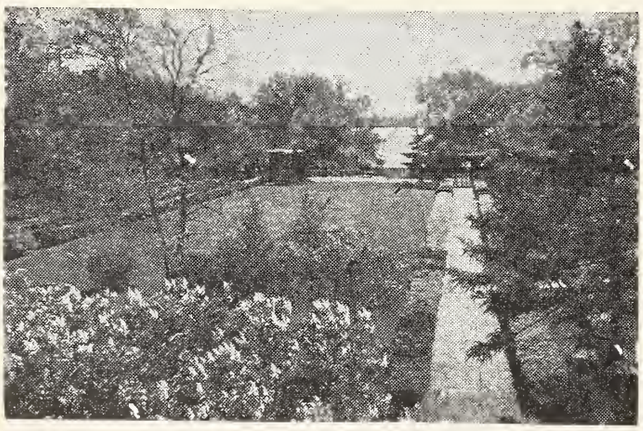
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local scripts over the air. These scripts were then eligible for state judging in Lansing. Serving as state judges were the head of the department of Written and Spoken English at Michigan State College, one member of the research department of the Michigan Tuberculosis Association and the state chairman of the TB Project for the Auxiliary to the Michigan State Medical Society.

While local Medical Auxiliary TB chairmen were making personal contacts with school officials and clubs, Miss Minetta Nicolai, director of the school projects for the Michigan Tuberculosis Association, was sending letters to all the high school superintendents and teachers of English and Speech in the state of Michigan explaining the project. All reference materials came from her office, as well as travel arrangements for the winners, selection of the state judges, and the arrangements for broadcasting time over station WKAR to the entire state. The secretaries of the county Tuberculosis Associations were alerted, and they, too, made personal contacts with schools and Medical Auxiliaries.

Mrs. T. Grover Amos, president of the Auxiliary to the Michigan State Medical Society, presented the coveted gold medals to Ursuline Balewicz of Saginaw, Janet Rae Lake of Lake City, Jean Miller of Bay City, Frances Cotter of Centerville and Marilyn Corey of Stephenson. Twenty-one more students received Honorable Mention for their efforts. The six chosen winners received an expense-free trip to Lansing where they were the guests of the sponsors, and the opportunity to broadcast their talks over a state-wide hookup at station WKAR in East Lansing.

Perhaps the impact of a project of this type is best illustrated in the words of one of the contestants, an Indian boy from northern Michigan, who wrote: "I am fortunate enough to attend a school where health education is stressed and information on the cause, prevention, and care of tuberculosis is taught or I might be in a sanatorium, as is my brother, who did not have the chance to learn the facts about the disease. I know that if knowledge and enlightenment are received in time it may mean the balance between life and death. . . ." Results such as this indicate that the merit of this project lies in its purpose, which is education through information.



Communication

MEDICAL OFFICERS

Dr. P. L. Ledwidge, President
Michigan State Medical Society

Dear Doctor Ledwidge:

I want to take this opportunity to bring to your attention a matter of critical concern to the Michigan National Guard. As you no doubt know, the National Guard is again reforming its ranks after its outstanding record of service in World War II. The new Michigan National Guard has been allotted a strength more than triple of that in its pre-war days and is designed as an actual force in being ready to participate as an M-Day force in case of national emergency.

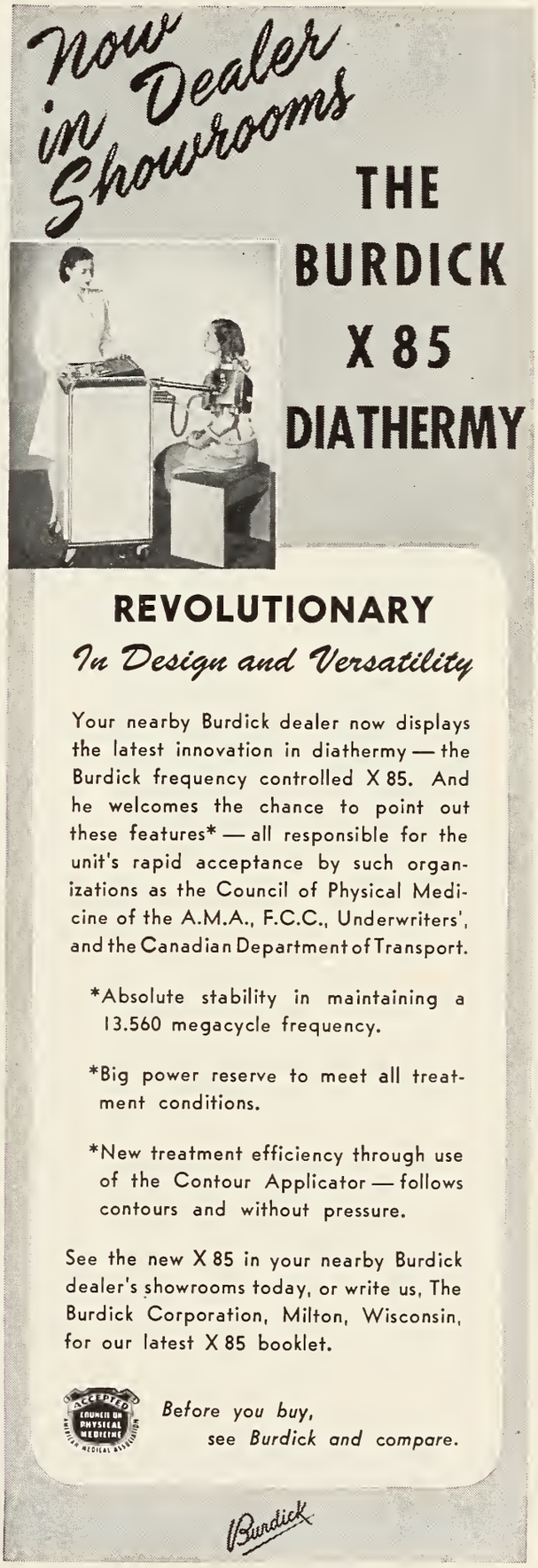
While we have already organized 110 units with an aggregate strength of 5,500 officers and men, a critical shortage of qualified medical officers is creating an adverse situation in many of our units. Specifically, organization of medical units at Bay City, Jackson, Lansing, Detroit and Grand Rapids, and to a certain extent in other cities, is being hindered by lack of qualified medical officers. Furthermore, practically all units are having excessive difficulties in obtaining medical assistance for the examination of prospective recruits.

I realize that many of the members of your profession have served for long years on dangerous assignments in the recent war and they are probably encountering many personal problems in re-establishing their practices. I feel sure, however, that many of the younger members of your profession are well qualified to contribute a small share of their services to their state and their nation by actively affiliating with their home-town National Guard units. Many of these younger men are indebted to the government for a large part of their professional training, and service in the National Guard would appear to be a logical means of repaying that indebtedness.

Members of your profession who are already commissioned in the Organized Reserve Corps may accept commissions in the National Guard without loss of their reserve rank. They may also regain their reserve commissions if at any subsequent time they wish to transfer from the National Guard back to the Reserve.

Furthermore, to make National Guard assignments more attractive to former medical officers, the National Guard Bureau recently authorized us to fill vacancies for medical officers by assignment of qualified doctors who are one grade higher than that authorized by applicable tables of organization. This would mean, for instance, that in our Medical Detachment of the 125th Infantry, to be organized at Bay City, we could utilize one lieutenant colonel and two to four majors. Field artillery medical detachments at Lansing and Jackson could utilize two majors. The organization of all these units has been held up for lack of medical personnel, and the necessity for filling these medical officer vacancies is immediate if we are to meet our assigned objectives.

(Continued on Page 343)



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In Memoriam

NATHAN J. BICKNELL, M.D., Detroit, Michigan. Born 1895. Graduate of the University of Toronto Faculty of Medicine, Class 1920. Member of the Wayne County Medical Society, American Medical Association, and the Michigan State Medical Society. Dr. Bicknell expired January 28, 1948, at the age of fifty-two years, in Detroit, Michigan.

* * *

EZRA LINCOLN COVEY, M.D., Honor, Michigan. Born in Burr Oak, Michigan, August 30, 1873. Received education at Benzonia Academy, Grand Rapids Medical College, Class of 1899, and the University of Michigan Homeopathic Medical School, graduating with Class of 1907. Formerly member of the Grand Traverse-Leelanau-Benzie County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Covey died February 1, 1948, at Honor, Michigan, at the age of seventy-four and is survived by his wife, Evelyn and son, Norman.

* * *

RALPH D. ENGLE, M.D., Petoskey, Michigan. Born February 1, 1879, at Muskegon, Michigan. Received medical education at Albion College, and the University of Michigan Medical School, graduating with Class of 1906. He was a former member of the Northern Michigan County Medical Society, the Michigan State Medical Society, and the American Medical Association. Dr. Engle served as secretary of the Petoskey Board of Education for 36 years and was the medical member of the Board of Trustees of Lockwood General Hospital. He was charter member of the Petoskey Rotary Club, and for many years served Petoskey as City Health Officer, and also as County Coroner. Dr. Engle expired January 14, 1948, at the age of sixty-nine, in Petoskey, Michigan.

* * *

HOWARD BISHOP GARNER, M.D., Detroit, Michigan. Born 1867. He received medical training and education at the University of Michigan Medical School, graduating with Class of 1892. He was a member of the American College of Physicians and Surgeons, the Association of Military Surgeons, the Wayne County Medical Society, the American Medical Association, and in 1942 was elected to Emeritus Membership in the Michigan State Medical Society. Dr. Garner retired from active practice in 1944. He also was a member of the Caravan Shrine Club, Damascus Commandery No. 42, and the Hi-Twelve International. Dr. Garner expired February 13, 1948, at the age of eighty-one, in Detroit, Michigan.

* * *

CARRIE STAINES KELLOGG, M.D., Battle Creek, Michigan. Born in Bushnell Township, Montcalm County, November 11, 1867. Graduated from the American Medical Missionary College, Battle Creek, Michigan, Class of 1899. Dr. Kellogg was a member of the Battle Creek Sanitarium Medical Staff from 1900 until marriage in 1918 to W. K. Kellogg, founder of the Kellogg

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Company and the W. K. Kellogg Foundation. She was a member of the Calhoun County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Kellogg expired February 16, 1948, at the home of her niece near Fenwick, Michigan, at the age of eighty.

* * *

ARTHUR EDWARD LAMLEY, M.D., Blissfield, Michigan. Born June 18, 1885, in Blissfield, Michigan. Received education at the University of Pennsylvania School of Medicine, Class of 1909. Interned at Toledo Hospital. Served as Blissfield Health Officer. Member of the Lenawee County Medical Society, the American Medical Association, the Toledo Academy of Medicine, and the Michigan State Medical Society. He was a life member of the Blissfield Masonic Lodge. Lifetime hobby was horseback riding and he kept a stable of gaited mounts for that purpose. Dr. Lamley died February 10, 1948, at Adrian, Michigan, at the age of sixty-two.

* * *

JOSIAH K. LILLY, SR., Indianapolis, Indiana. Born 1862, Greencastle, Indiana, son of Colonel Eli Lilly who founded present company May 10, 1876. Josiah Lilly in 1880 entered Philadelphia College of Pharmacy & Science. Upon graduation returned to Indianapolis to become superintendent of the plant, subsequently becoming president of the Eli Lilly & Company in 1898 in which capacity he served for thirty-four years. In recognition of his services in civic, scientific, educational, and cultural organizations, eight colleges and universities conferred honorary degrees upon Mr. Lilly. Mr. Lilly passed away February 8, 1948, at the age of eighty-six, in Indianapolis, Indiana.

H. LEE SIMPSON, M.D., Detroit, Michigan. Born at Adrian, Michigan, in 1878. Graduated from University of Michigan School of Medicine in 1904. Interned at Cleveland General Hospital for one year. Completed postgraduate studies in London. Member of the American College of Surgeons, American Academy of Otolaryngology, Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. He also was a member of the Detroit Athletic Club, the Detroit Golf Club, and Meadowbrook Country Club. Doctor Simpson died February 3, 1948, at Detroit, Michigan, aged sixty-nine.

COMMUNICATION

(Continued from Page 341)

In view of the above, therefore, the Michigan National Guard respectfully requests the assistance of your society in making our needs known to the medical profession of Michigan. We feel sure that if this matter were publicized through your JOURNAL and through your communications to the county medical societies qualified medical officers will again volunteer their services in this important cause. Medical officers will, of course, draw the pay of their grade for duties performed, the same as other National Guard personnel. Interested members of your profession may be referred either to this office or to commanding officers of local National Guard units. I would appreciate any assistance that you may be able to give us in this regard.

Sincerely yours,
GEORGE C. MORAN
Colonel, AGD, Michigan NG
Acting The Adjutant General of Michigan

Say you saw it in the Journal of the Michigan State Medical Society

What's What

Indiana law now requires annual re-registration of license to practice the healing art in that State.

* * *

Renew your federal and state narcotic licenses on or before July 1.

* * *

Norman F. Miller, M.D., Ann Arbor, is the author of a special article "Cancer of Uterus and Ovary" which appeared in JAMA of January 17, 1948.

* * *

Paul B. Magnuson, M.D., Chicago, has been named Chief Medical Director for Veterans Administration. Dr. Magnuson was former Professor of Surgery at Northwestern University Medical School.

* * *

Holy Cross Hospital, Detroit, unveiled a plaque to commemorate the names of donors who were instrumental in raising funds necessary to secure the present hospital building. The ceremony was held January 25. An inspection of the hospital followed.

* * *

Lawrence W. Rember has been appointed assistant in charge of the AMA Public Relations Program. He assumed his duties on December 16, the same day that the New York-Chicago firm of Theodore R. Sills & Co. was retained as public relations counsel to assist him.

* * *

Further hearings on the health bills, S. 545 and S. 1320, were resumed in Washington, D. C., on January 26-27-28. Isadore Falk of the Social Security Administration continued his testimony which was suddenly terminated last summer.

* * *

The Family Doctor is written up by James S. Pooler in the *Detroit Free Press* of February 8, 1948. This recognizes the family doctor as a very reliable man, knowing the families he serves, and with a wealth of experience as well as personal knowledge—a well-written article.

* * *

Interim Session of the A.M.A.—Registrations at the Interim Session held in Cleveland early in January were 4,230. These were 1,896. Fellows and 2,334 interns, medical students, residents, industrial health physicians, and nurses.

(Continued on Page 346)

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(Continued from Page 344)

The American Board of Ophthalmology will hold its practical examinations in Baltimore, May 20-25, and in Chicago, October 6-9.

Applicants for the January, 1949, Written Qualifying Test must be filed with the Secretary before July, 1948. Write S. Judd Beach, M.D., Portland, Maine.

* * *

Genesee County Medical Society will hold its Third Annual Cancer Day at Hurley Hospital, Flint, on March 31. Five nationally known speakers in the field of cancer will appear on this one-day conference, to which all members of the Michigan State Medical Society are cordially invited. (See program, page 254)

* * *

The Council of the Michigan State Medical Society, in annual session on January 23-24, remitted the MSMS dues and assessments of all MSMS members who are now in active military service. Following the custom of previous years, The Council ruled that the 1948 MSMS dues and assessment will not apply to doctors of medicine in active military service during the current year.

* * *

Fellowships leading to a Master's degree in Public Health are being offered to any qualified U. S. citizen between the ages of twenty-two and forty by the United States Public Health Service, through a grant from the National Foundation for Infantile Paralysis. Information may be obtained by writing the Foundation, 120 Broadway, New York 5, New York.

* * *

Aerial meetings of the American Academy of Pediatrics will be held (a) on April 29-May 2, at Statler Hotel, Buffalo, N. Y., and (b) on June 28-30 at Hotel Schroeder, Milwaukee, Wis. Registration may be made in advance by writing C. G. Grulee, M.D., 636 Church Street, Evanston, Illinois, enclosing registration fee of $10 (which includes banquet).

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, addressed the annual meeting of the Wayne Out-County Chapter of the Michigan Society for Crippled Children on February 2. His subject was "Rheumatic Fever and the Michigan Plan." Dr. Foster also has been invited to address the Windsor, Ontaria, Rotary Club on March 29. He will speak of "The Success of Voluntary Programs of Medical Service in America."

* * *

The financial reports of the Michigan State Medical Society for 1947 appear in this number of the JOURNAL on pages 323-328. The budgets for 1948 also are published.

The Ernst & Ernst audit, completed early in January, was presented to The Council in Annual Session on January 22-23-24, and then was rushed to the printer for publication in the March issue of THE JOURNAL, as customary in former years.

(Continued on Page 348)



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(Continued from Page 346)

Paul R. Hawley, M.D., Major General in the Army, recently in charge of the Veterans Administration medical department, resigned December 31, 1947. He has been appointed head of the Blue Cross-Blue Shield, with headquarters in Chicago. He thus becomes responsible for the Nation's voluntary prepayment health care plans, which had enrollments of 29,250,000 and 7,250,000 respectively, on January 1, 1948.

This Year of Decision

Following are extracts from recent telegraphic communications between the chairman and the administrator of the National Physicians Committee.

Edward H. Cary, M.D., Dallas, Texas, stated: "President Truman's proposals for enactment of a compulsory health insurance law, if adopted, would inevitably lead to the political distribution of medical care in this country. This would cause deterioration in the quality and effectiveness of health services and the regimentation of physicians and the people."

Administrator Pratt stated: "When the proposals are analyzed and understood the health professions will respond in greater numbers than ever before; they will rally to this call to provide maximum strength; they will fight this menace to the American way of life to a final conclusion. Immediate continuous and aggressive action is essential in this 'year of decision.' "

Peter A. Volpe, M.D., formerly of Worthington, Ohio, has been appointed Medical Director of the Veterans Administration for Michigan, Ohio, and Kentucky. Dr. Volpe was engaged in private practice in Columbus, Ohio, until he entered military service in 1942. He became associated with VA in 1946. He will be responsible for the general medical program policies of the ten VA hospitals, four regional offices, and one veterans' domiciliary in the area.

* * *

R. Wallace Teed, M.D., of Ann Arbor has two Kodachrome pictures in the January 1948 *National Geographic* Magazine, Plate IV, page 100. These pictures were taken on Tinian in the Mariana Islands in 1945. They show two airships, rather the elaborate decorations on the noses of the ships. One is "Accentuate the Positive," the second was "the Great Artiste," the ship which carried and dropped the atom bomb that destroyed Nagasaki on August 9, 1945. The pictures are very good, and certainly commemorate an historic event.

* * *

Michigan Pathological Society—The next regular meeting of the Michigan Pathological Society will be held at

(Continued on Page 350)



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(Continued from Page 348)

the W. A. Foote Memorial Hospital, Jackson, Michigan, on April 17, 1948 at 3 P.M. The scientific program will include a discussion of "Diagnostic Problems in Pathology."

* * *

Five officers of the AMA will represent the medical profession in organizing the new Pharmaceutical-Medical Research Foundation, a wholly public institution in purpose, conduct and service. They are R. L. Sensenich, M.D., South Bend, President-Elect of the AMA, who will serve as chairman; E. L. Henderson, M.D., Louisville, Ky., Board of Trustees Chairman; Ernest E. Iron, M.D., Chicago, Secretary of the Board of Trustees; Morris Fishbein, M.D., Chicago, Journal Editor; and Austin Smith, M.D., Secretary of the Council on Pharmacy and Chemistry.

* * *

Taxes Take Their Toll.—The incentive to thrift and initiative has been destroyed. American industry's unprecedented growth has been made possible by the savings of thrifty individuals. In addition, there were substantial rewards for the citizens who, through his inventiveness, enterprise, and diligence, contributed to the economic growth of the nation. Today there is no incentive to work hard, to save, and to invest. In a recent *Fortune* poll, U. S. business executives were asked: *"If you could double your income by working two or three hours more a day, would you do so?"* The answer from 70 per cent of the executives was: "No."

* * *

Propaganda Money.—Michael Davis, head of one of the groups organized to promote socialized medicine and the Wagner-Murray-Dingell bills, has a terrific squawk. He complains that the medical profession, through the National Physicians Committee, had spent about $900,000 in the fight against the Wagner-Murray-Dingell bills. The fact that that was private money freely given for the purpose does not enter his mind. But he has no squawk when Isadore Falk, Chief Statistician for the Federal Security Administration, spent without authority $22,500,000 of the people's tax money, trying to force this subversive legislation on the United States, and that contrary to law.

* * *

Uniform Fee Schedule for Government Agencies.—The latest group to adopt the Michigan State Medical Society's Uniform Fee Schedule is the Michigan Association of Osteopathic Physicians and Surgeons, Inc. It was adopted officially by their House of Delegates, and became "Effective in Michigan November 3, 1947." It is printed in full in their December Bulletin, pages 21 to 30, verbatum, including the numbering system for items, and the only recognition that the Michigan State Medical Society had anything to do with it is the sentence "The fee for a given 'AA' service will be de-

Say you saw it in the Journal of the Michigan State Medical Society



termined by *arbitration and agreement* between the agency and the concerned state osteopathic association or state medical organization."

* * *

Heart ailments and cancer were the No. 1 and No. 2 killers in the lineup of fatal diseases last year. Together they accounted for nearly 72 per cent of the deaths among American men and women.

This was the experience of The Mutual Life Insurance Company of New York, according to a study made public of the causes of death among its 1,000,000 policyholders in 1947.

Diseases of the heart and circulatory system caused more than 57 per cent of the deaths in all age groups combined but hit hardest among people over sixty years of age where they accounted for nearly 62 per cent of deaths. Cancer, on the other hand, was most severely felt in the ages forty to fifty-nine group, where it caused about 16 per cent of deaths. Mortality from cancer in all age groups combined was 14.6 per cent of the total deaths from all causes.

Accidents ranked third among the killers. The heaviest toll was among those under forty years of age, where accidents were the principal cause of death and accounted for nearly 36 per cent of all deaths in this age group. Suicide and tuberculosis also hit youth harder than they did the older age groups. Suicide accounted for more than 6 per cent and tuberculosis 4 per cent of deaths in the under age forty group.

President's Budget Message.—The 1949 budget contains expenditures for social welfare, health and security estimated at $2,028,102,127.00, including $116,000,000 for proposed legislation. The estimate involves increases for insurance program. The recommendations for a health insurance program assume a total initial payroll tax of one-half of 1 per cent of the individuals' salaries up to $4,800.00 a year, effective January 1, 1949, to furnish a basis for establishing eligibility for benefits and to build up an operating reserve. Permanent rates to make the program mainly self-financing would be set up in a year or two.

Included in the budget is an increase for education and general research which results mainly from the proposed grants by the Federal government to States to aid elementary and secondary education and from the proposed establishment of a National Science Foundation. The budget estimates assume the creation of the National Science Foundation—passage of such legislation was again urged. $615,000,000.00 is estimated for the hospital and medical care of the Veterans Administration. The operating expenses of this program will increase substantially because of the steady rise in patient load. The out-patient care program will cost slightly less than the current year.

The President, in his message, stated that he intends shortly to discuss, in a special message to Congress, proposals that would have immediate fiscal effects on the following items: the extension coverage of old-age and survivors insurance; increase in individual benefits; *pro-*



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vision for a national system of health insurance and improved services and facilities for public health and medical care; extension of unemployment compensasation pertaining to Federal aid for public assistance so as to relate them to the financial resources and needs of each State.

* * *

At AMA in Cleveland—The following Michigan physicians, members of the Michigan State Medical Society, registered at the Interim Session of the AMA at Cleveland, Ohio, January 5-6-7-8, 1948:

Ira Avrin, Detroit.

Charles J. Barone, Detroit; Wyman D. Barrett, Detroit; O. O. Beck, Birmingham; Edgar A. Bicknell, Detroit; H. C. Bodmer, Kalamazoo; Albert J. Boyle, Detroit; Stanley A. Brown, Detroit; A. S. Brunk, Detroit; Bruno B. Brunke, Detroit; Julius Y. Burnstine, Detroit.

Clarence L. Candler, Detroit; Joseph Carp, Detroit; L. G. Christian, Lansing; Eisman Clarencett, Detroit; Ronald E. Clark, Detroit; Wilfrid Cowan, Detroit.

Graham L. Davis, Battle Creek; Isla G. DePree, Grand Rapids; Harold Drinkaus, Detroit; Victor Droock, Detroit; Don H. Duffie, Central Lake.

S. G. Epstern, Detroit.

David H. Fauman, Detroit; D. L. Finch, Battle Creek; L. Fernald Foster, Bay City.

Harold H. Gay, Midland; Joseph P. Gilding, Vicksburg; Lawrence E. Grate, Charlevoix; Wm. L. Green, Kalamazoo; Thomas K. Gruber, Eloise.

O. J. Hastings, Detroit; Wilfrid Haughey, Battle Creek; Leslie T. Henderson, Detroit; Raymond Hussey, Detroit; Wm. A. Hyland, Grand Rapids.

E. B. Johnson, Allegan.

Q. S. Katzman, Detroit; A. H. Keefer, Concord; Claude R. Keyport, Grayling; Delmas K. Kitchen, Detroit; Shmarya Kleinman, Detroit; Earl J. Knaggs, Wyandotte; E. B. Knobloch, Detroit; Edward J. Koerber, Detroit; F. S. Kucmierz, Detroit.

Leonard Wm. Lang, Detroit; A. F. Lecklider, Detroit; P. L. Ledwidge, Detroit; Ezra Lipkin, Detroit; E. Clarkson Long, Detroit; John J. Long, Detroit; J. K. Losowski, Hamtramck; Neil H. Lullenberger, Ann Arbor; Earl F. Lutz, Detroit.

John E. Maczewski, Hamtramck; Morris H. Marks, Detroit; R. M. Martin, Detroit; Leland R. McElmurry, Lansing; N. D. McGlaughlin, Wyandotte; J. D. Miller, Grand Rapids; Myron H. Miller, Detroit; Max Mosen, Detroit; Thomas H. Murray, Detroit.

Rudolf J. Noer, Detroit; Tom Norup, Berkley.

G. C. Penberthy, Detroit; G. N. Petroff, Pontiac; J. W. Podezwa, Detroit; Joseph L. Posch, Detroit; Earl C. Potter, Lansing; John J. Prendergast, Detroit.

Harold F. Raynor, Detroit; Frank L. Rector, Ann Arbor; Rufus H. Reitzel, Mt. Clemens; F. P. Rhoades, Detroit.

Irvin W. Sander, Detroit; Raymond J. Screen, Farmington; C. D. Selby, Detroit; E. S. Sevensma, Grand Rapids; Burt R. Shurly, Detroit; John M. Sisson, Detroit; Edward F. Sladek, Traverse City; Wm. J. Stapleton, Detroit; S. D. Steiner, Lansing; Thaddeus Stokfisz, Detroit; Raymond H. Suwinski, Hamtramck; John C. Szejda, Detroit.

Elmer C. Texter, Detroit; A. A. Thompson, Mt. Clemens.

Bert Van Ack, Grand Rapids; Daniel Van Woerkom, Grand Rapids; Harold E. Veldman, Grand Rapids.

Everal M. Wakeman, Dearborn; Arch Walls, Detroit; Alec Whitely, St. Clair Shores; Alfred H. Whittaker, Detroit; D. Bruce Wiley, Utica; Charles F. Wilkinson, Jr., Ann Arbor; Harry C. Wissman, Detroit; Winston R. Wreggit, Highland Park.

Please Meet...

MARVIN BOSHOVEN



Marvin Boshoven became associated with PM's Grand Rapids office early in 1946. He is a graduate of Grand Rapids Junior College, and was with General Motors for some years before joining the Coast Guard. His hobbies are hunting and fishing.

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During the past seven years, with little publicity and modest financial support, this Committee has provided more than a million dollars worth of desperately needed medical, surgical and dental supplies and publications to stricken areas overseas. These materials are sent to hospitals, physicians and dispensaries giving *free* medical care to the needy.

Our colleagues in Europe and the East are still faced with an appalling lack of basic medical equipment. Some have not even seen a medical journal or textbook printed since 1939, and are woefully uninformed of many of the latest medical advances.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

LABORATORY MANUAL OF MICROBIOLOGY FOR NURSES. By Elizabeth S. Gill, R.N., Instructor in Nursing, Department of Nursing College of Physicians and Surgeons, Columbia University, New York; and James T. Culbertson, Ph.D., Professor of Bacteriology and Parasitology University of Arkansas School of Medicine, Little Rock, Arkansas, Formerly Assistant Professor of Bacteriology College of Physicians and Surgeons, Columbia University, New York. New York: G. P. Putnam's Sons, 1947. Price $1.50.

This is a very handy manual, loose leaf type, printed imitation of typrewriter, double-spaced, making it handy and easily used. Instructions for preparing media and detailed outline of laboratory procedures are fully given. The cover is flexible.

A MANUAL OF CLINICAL THERAPEUTICS—A Guide for Students and Practitioners: By Windsor C. Cutting, M.D., Professor of Therapeutics, Stanford University School of Medicine, San Francisco, California. Second Edition. 712 pages, with 30 illustrations. Philadelphia and London: W. B. Saunders Company, 1948. Price $5.00.

Dr. Cutting has furnished a workable guide in therapeutics. The lastest procedures are advanced in this second edition. Many changes are given. The discussion on allergy, especially asthma, is up to date, calling attention to many problems and their solution.

The text is developed on the basis of treatment of general principles, therapy of symptoms such as diarrhea, constipation, vomiting, et cetera. This covers infections, bacterial and others, including virus, mycotic and postozal. Nutritional diseases, deficiency (vitamin), endocrine and metabolic, are well discussed. The diseases of the various systems are discussed. A complete appendix rounds out the book. It is pocket size but comprehensive and should prove valuable to students and practitioners.

INTERNAL MEDICINE IN GENERAL PRACTICE. By Robert Pratt McComb, B.S., M.D., F.A.C.P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Second edition. 741 pp. with 122 illustrations. Philadelphia: W. B. Saunders Co., 1947. $8.00.

Several comprehensive books on diagnosis have been presented to the medical profession this past year. "Internal Medicine in General Practice" is one of the most useful and complete yet issued. It details a common sense procedure for the arrival at a definite conclusion. The procedures outlined inevitably lead to a sound basis of differential diagnosis. A thorough study of the taking of a history and making a complete physical examination will serve any practitioner well, and he will learn much from the suggested laboratory procedure. —M.J.C.

MINOR SURGERY. By Frederick Christopher, B.S., M.D., F.A.C.S., Associate Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. Sixth edition. Philadelphia and London: W. B. Saunders Company, 1948. Price $12.00.

The host of practitioners who perform minor surgery with treatment of fractures, burns, infections, circulatory disturbances and allied conditions as office or outpatient hospital practice, and who have used this book as a well-thumbed standard reference will welcome this new,

bigger edition with 937 illustrations and 1026 pages. Changes in the use of the antibiotics and the sulfonamides occupy an important place in the chapter on infections and streptomycin therapy is discussed.

Many additions have been made to the enlarged chapter on treatment of burns, particularly the physiology of burn therapy, and an extensive bibliography is provided. Extensive revision of the sections on thrombophlebitis and phlebothrombosis has been carried out, technique of lumbar procaine block illustrated, and prophylactic femoral vein ligation discussed. Newer methods of dealing with pilonidal sinus are included and other plastic procedures derived from the medical experience of World War II.

Refrigeration anesthesia, use of gelatin sponge and related materials for the local control of hemorrhage, early postoperative ambulation, sternal puncture and use of the Miller-Abbott tube are dealt with. Novocain injection in bursitis, minor fractures and in sprains; and prosthetic restoration of amputated fingers are discussed in the light of most recent information. The chapter on pre- and postoperative care has been enlarged, with adequate coverage of such important factors as fluid and electrolyte administration, hypoproteinemia, wound healing, shock, Rh factor, and many others. This fine volume is a worthwhile addition to any physician's library.

—S.B.W.

PHARMACOLOGY, THERAPEUTICS AND PRESCRIPTION WRITING—For Students and Practitioners. By Walter Arthur Bastedo, Ph.G., Ph.M. (Hon.), M.D., Sc.D. (Hon.), F.A.C.P., Consulting Physician, St. Luke's Hospital, N. Y.; St Vincent's Hospital, Staten Island, and the Staten Island Hospital; President, US.P. Convention 1930-40; Member Revision Committee, U.S.P. Formerly Curator of the N. Y. Botanical Garden; Attending Physician, City Hospital, N. Y.; Instructor in Pharmacology, Cornell University; Associate in Pharmacology and Therapeutics and Assistant Clinical Professor of Medicine, Columbia University. Fifth edition. 840 pages, with 82 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price $8.50.

The fifth edition of Bastedo's Pharmacology, Therapeutics, and Prescription Writing is now available. This book has been a standard pharmacology for physicians for so many years that little review is necessary. Suffice it to say, it is Bastedo's and has been brought up to date to include all modern discoveries in medicine and their application to the treatment of disease. The recent advance in chemical and biological medicines has placed remarkable and powerful agencies in the physician's hands, and each one should be entirely familiar with their application.

—M.J.C.

EMOTIONAL MATURITY THE DEVELOPMENT AND DYNAMICS OF PERSONALITY. By Leon J. Saul, M.A., M.D., Associate Professor of Psychiatry, Temple University School of Medicine Special Lecturer in Psychiatric Information, Bryn Mawr College. Philadelphia: J. B. Lippincott Co. Price $5.00.

This immediate postwar period has been marked by numerous articles and books on psychiatric subjects. For some time prior to the recent war, the primary emphasis was on "the insane." Psychiatric eyperiences of World War II have again emphasized that the insane represent the extremes of emotional disorder and the statement of the author that "the primary interest of modern psychiatry is no longer the insane" is obviously a significant point. Consequently, if our experiences in the recent war are valid, we must turn our attention to those disorders resulting from the emotional tensions of living.



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Surgical Anatomy and Clinical Surgery, two weeks, starting April 12, May 10.
Surgery of Colon and Rectum, one week, starting April 26, May 24.
Surgical Pathology every two weeks.
FRACTURES and Traumatic Surgery—Intensive course, two weeks, starting June 7.
PEDIATRICS—Intensive course, four weeks, starting April 5.
GYNECOLOGY—Intensive course, two weeks, starting April 26, June 7.
OBSTETRICS—Intensive course, two weeks, starting April 12, June 21.
MEDICINE—Intensive course, two weeks, starting April 26.
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DERMATOLOGY—Formal course, two weeks, starting April 26.
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In this book, the author discusses the emotional forces in the development of the personality, emphasizing the points of emotional immaturity and specifically the conflict between dependent tendencies on the one hand and independence and freedom on the other. In this regard, the balance between "giving" and "getting" and its relationship to maturity is significant. Other characteristics of maturity include freedom from inferiority feelings, egotism, and competitiveness, and last, but not least, a firm sense of reality. The significance of the persisting childhood patterns with regard to the emotional influences on personality are well covered in the second section of the book. Experiences of the war have taught us that external stress is very important in causation of emotional disorders. If the stress is sufficiently great or prolonged as most anyone can respond with a severe emotional reaction. Another point of great importance emphasized in this work is that of specific emotional vulnerability which, in the opinion of the author, results from the internal factors and implies that such influences alter the degree of stress necessary to produce an emotional illness. The resultant reactions utilize and alter the basic patterns of fear, flight and aggression in order to produce adaptation to all of these influences.

On the whole, one can say that this is a readable presentation of an intricate and complicated subject and should prove valuable to those professional people who are dealing with emotional disorders. In the opinion of this reviewer the book is considerably more than the primer suggested on the jacket, and one wonders if it can be read with great profit by those who have only a limited knowledge of the subject. F.O.M.

UNIPOLAR LEAD ELECTROCARDIOGRAPHY, including Leads, Unipolar Extremity Leads and Multiple Unipolar Precordial Leads. By Emanuel Goldberger, B.S., M.D., Adjunct Physician, Montefiore Hospital, New York; Cardiographer and Associate Physician, Lincoln Hospital, New York: Diplomate of the American Board of Internal Medicine; Clinical Lecturer in Medicine, Columbia University, Faculty of Medicine. With 88 illustrations. Philadelphia: Lea & Febiger, 1947. Price $4.00.

This monograph is the result of seven years of intensive study and investigation on the use of unipolar leads in electrocardiography by the author. He originally used the method devised by Wilson and his associates and in the course of his work he developed a method of obtaining "augmented" unipolar extremity leads and a simple indifferent electrode of zero for use with such leads.

Most reference works on electrocardiography describe the three standard leads alone or with one or more precordial leads but in this text each abnormality is described in terms of the three standards leads, the three "augmented" unipolar extremity leads and the six unipolar precordial leads. All of these leads are shown in basic unipolar lead patterns.

The author states that unipolar leads are advantagious in many clinical conditions, for example: the interpre-

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tation of axis deviation; the diagnosis of abnomalities of the q waves, especially Q3; the differentiation of pulmonary embolism from posterior infarction; the diagnosis of small myocardial infarcts; the diagnosis of bundle branch block; the diagnosis of right ventricular hypertrophy; the interpretation of tracings when standard leads appear normal or when minimal changes are present in the standard leads, et cetera.

For anyone desiring the most recent advances in electrocardiography and to have them very clearly and concisely presented with adequate illustrations, this book can be highly recommended. G.W.S.

A PRIMER OF CARDIOLOGY. By George E. Burch, M.D., F.A.C.P., Associate Professor of Medicine; Senior Visiting Physician, Charity Hospital; Consultant in Cardiovascular Diseases, Ochsner Clinic; Visiting Physician, Touro Infirmary, New Orleans, and Paul Reaser, M.D., Instructor in Medicine, Tulane University School of Medicine; Assistant Visiting Physician, Charity Hospital, New Orleans. With 203 illustrations. Philadelphia: Lea & Febiger, 1947. Price $4.50.

Of the many volumes on basic cardiology available to the student and practitioner, this book should be a "must" on their list. Its comprehensive scope is such that it can be used as a starting point for the study of any of the phases of cardiology.

The author's style is very clear and informative. No statements are made without substantiating reasons and ample descriptive illustrations abound throughout. All this enables the reader to understand every phase of the subject with ease.

The book is divided into five main divisions. The first deals with the general anatomic considerations as an aid to physical diagnosis. Following this there is a discussion of the approach to the diagnosis of heart disease, of the approach to a clinical cardiac evaluation, of the common types of heart disease, and finally of the bedside diagnosis of cardiac irregularities. The common types of heart disease and causes of heart failure are taken up individually and each considered in full. Figures correlating the clinical records, electrocardiograms, pulse tracings and phlebograms are presented frequently to teach the reader to think of the clinical manifestations in terms of circulatory dynamics and basic physiologic principles.

Although this book is primarily for the students and for the beginner in cardiology, it contains such a wealth of valuable material that it can be recommended just as surely to the experienced cardiologist. —G.W.S.



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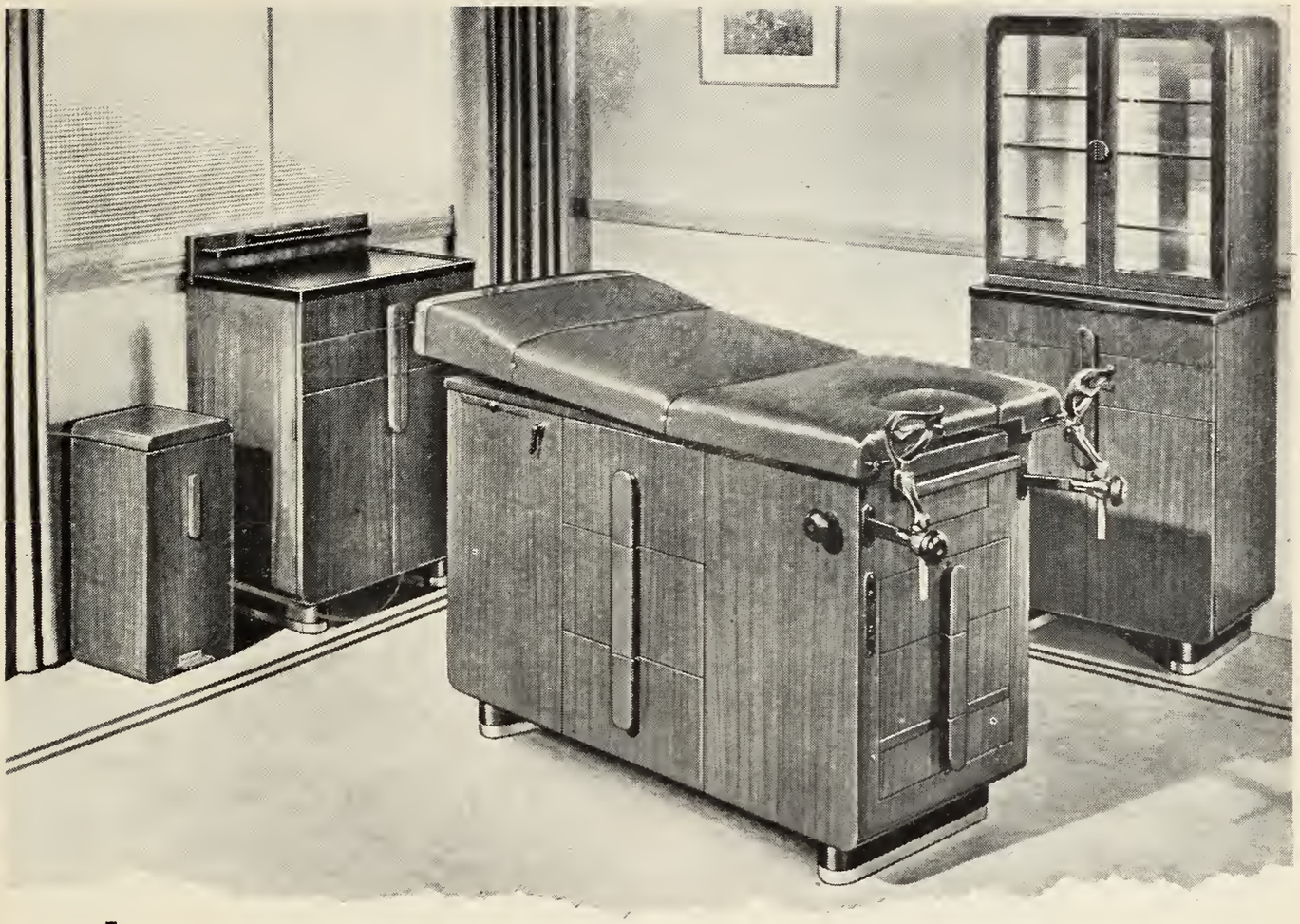


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Michigan Foundation for Medical and Health Education

PRESIDENT'S REPORT



E. I. Carr, M.D.

This is the third annual meeting of the Foundation but really only the second annual meeting after full calendar years, the first following close upon the heels of our organization meetings of September and October, 1945. In other words, the existence of this Foundation covers two and one fourth years. The uncertainty and commotion in world affairs, without doubt, has had some effect upon this Foundation, perceptible or not.

The work of the year started out with the distribution of the brochure, "Leading in Learning," which was in the process of printing and was introduced to this membership at the last annual meeting. These were sent to every practicing doctor of medicine in Michigan, to all officers of the state medical societies of the nation, to inquiring groups and individuals, to certain lawyers and trust officers and to some who provide desirable distribution and they were available at several special meetings, conferences, et cetera. These brochures are still available for any distribution desired.

A condensed announcement in a pamphlet form of pocket size was included in the early plans. This was developed this year, with the valued aid of Mr. Hugh Brenneman, and was published under the title, "Invest in Health." Over 14,000 have been distributed upon the request of those who signified that they could use these pamphlets to the good advantage of the Foundation.

To anyone who feels that our program has been too ambitious, I refer him to the plan for the Oklahoma Medical Research Foundation. It has secured $434,300 from 457 physicians toward a goal of $1,000,000 from the Oklahoma physicians alone. The goal from pharmacists is $300,000, from dentists the goal is $255,000 and from the nurses the goal is $50,000, one-half of the last already having been raised. They, too, have withheld their campaign among the laity until their campaign among the professional groups has been well developed. The goal of the professional groups is the nucleus for a $3,000,000 Founding Campaign. An outstanding and important difference between the Oklahoma and Michigan Foundations in fund raising is the former's request for an annual contribution over a period of time varying from two and one-half to five years instead of a request for a pledge of a single sum. This idea, however, has been the subject of recent discussion by the Michigan Board of Trustees.

Gov. Kim Sigler, in addressing the County Secretaries and Public Relations Conference in Detroit in 1947, did a splendid job in emphasizing the importance, the purposes and the opportunities of the Michigan Foundation. Following this luncheon meeting, your president, who was the invited chairman of the luncheon program, divided the audience into two groups; one was addressed by Vice President B. R. Corbus and the other by Trustee J. M. Robb. In this intimate way, representatives of medical organization from every county of Michigan were provided with facts concerning the Foundation to carry home to their respective societies.

The Foundation is a sponsor of the Michigan Postgraduate Clinical Institute which was inaugurated and was presented in a three-day meeting in Detroit last March as an annual affair. Two trustees of this Foundation appear on the planning committee, and representatives of the Foundation are on the program of 1947 and of 1948. A request and opportunity have been presented since the last meeting of the Board of Trustees to carry out this coming year, in connection with the institute, a breakfast program on Thursday, March 11, 1948, at 8:00 A.M. Dr. Louis J. Hirschman has accepted an invitation to be speaker of the occasion and to present a program to improve rural medical service by aiding in the education of those selected who will agree to serve, after graduation and internship, in general practice in rural communities either for a specified length of time or until their loans are repaid. The dearth of rural

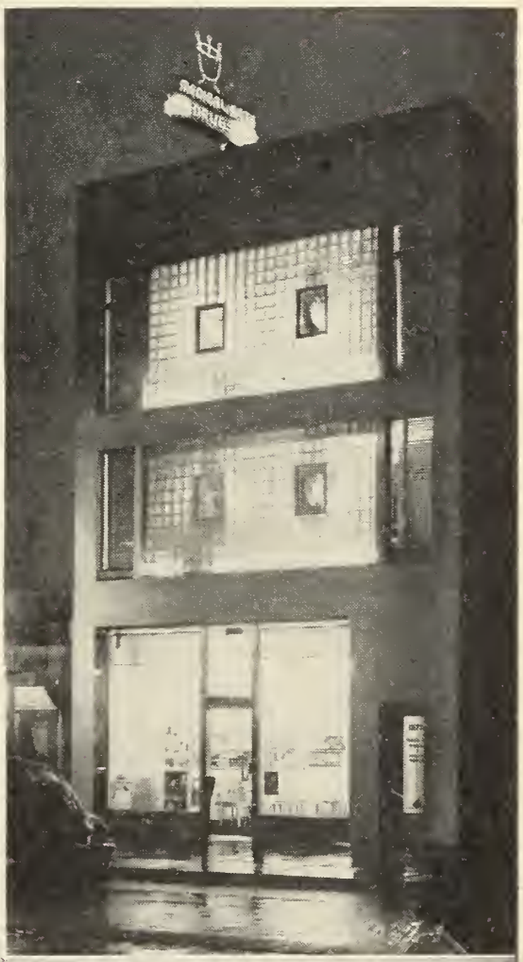
(Continued on Page 370)

**Presented by E. I. Carr, M.D., Lansing, at the Annual Meeting of the Michigan Foundation for Medical and Health Education, Inc., Book-Cadillac Hotel, Detroit, January 24, 1948.*

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PRESIDENT'S REPORT

(Continued from Page 368)

medical care is one of the most challenging problems at the present time before the medical profession and the remedying of this lack now by this Foundation is regarded by many as the greatest opportunity for appealing service within the facilities of this Foundation. A revolving fund and not a grant is the popular and practical present opinion. It is possible that a plan of financing the revolving fund may be evolved at the breakfast. Similar plans have been developed in Mississippi, Illinois and other states, and the subject has been regarded as of sufficient popular interest to warrant descriptive articles in popular magazines (*Ladies' Home Journal*).

The Foundation was one of the sponsors and participants of the two-day Michigan Rural Health Conference, patterned after the national conference in Chicago earlier in the year. This state conference on rural health, held last September in East Lansing, is one of the first to be held, and the success of this year's conference has created a demand that it become an annual event.

Dr. Charles P. Loomis, Dr. Charles R. Hoffer and Dr. Edgar A. Schuler, professors and sociology researchers of Michigan State College, are undertaking a survey of Michigan concerning medical care in rural areas. This unique and thorough plan has been scrutinized by the State Medical Society, the American Medical Association, and others. Your president has met with these men and on two occasions with Dr. Frank Dickinson, Director of the Bureau of Economic Research of the American Medical Association. The Board of Trustees has voted $500.00 for the coming year to aid in this work of the survey.

The Michigan State Bar Association has inaugurated a Foundation which seems to be patterned after our Medical Foundation. I am sure that I speak for all in wishing them every success.

The November issue of THE JOURNAL of the Michigan State Medical Society and a letter, over the signature of your president as directed by the Board of Trustees, sent to the membership of the State Medical Society with the Secretary's Letter of December, have already resulted in fifty-four voluntary contributions aggregating $3,349.00 and varying in amounts from $5 to $1,000.

I must repeat an opinion that I have twice expressed to the Board of Trustees that this Foundation has passed the day of prospect and that the activity of appealing projects must become vividly evident for the preservation and development of this Foundation. We need these evidences for two sound reasons: first, to meet the natural inquiry of a giver who may justly ask, "What is the Foundation doing?" and second, the Treasury Department has already requested evidence of our philanthropies and requires this evidence before ruling a final tax exemption.

ERNST & ERNST REPORT ON THE MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION, INC., FOR THE YEAR 1947

We have examined the statement of assets of the Michigan Foundation for Medical and Health Education as of December 31, 1947, and the statement of fund balance for the year then ended, have reviewed the system of internal control and the accounting procedures of the Foundation and, without making a detailed audit of the transactions, have examined or tested accounting records of the Foundation and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

In our opinion, the accompanying statements present fairly the assets of Michigan Foundation for Medical and Health Education at December 31, 1947, and the transactions affecting the fund balance for the year.

ERNST & ERNST
January 12, 1948 Certified Public Accountants

STATEMENT OF ASSETS
December 31, 1947

ASSETS		
Cash on deposit at Michigan National Bank, Lansing		$ 15,011.70
Securities owned—at cost (aggregate market or redemption prices $55,922.15):		
United States Government bonds	$ 35,671.03	
Canadian Government bonds	14,343.75	
Bank stock	5,250.00	
Public utility stock	5,175.00	60,439.78
Total—representing Fund Balance		$ 75,451.48

STATEMENT OF FUND BALANCE
Year ended December 31, 1947

Balance at January 1, 1947			$ 70,676.16
ADDITIONS			
Contributions:			
From doctors of medicine	$7,640.00		
From Manistee County Medical Society	100.00	$7,740.00	
Dividends and interest	1,810.89		
Gain on redemption of bond	95.00	$9,645.89	
DEDUCTIONS			
Disbursements for expenses:			
Pamphlets and printed matter	$4,325.17		
Accounting services	165.54		
Travel and committee meetings	142.98		
Stationery and office supplies	113.47		
Fidelity bond	62.50		
Corporate registration fee	2.00		
Trustee's fee	36.25		
Bank collection fees	3.97		
Miscellaneous administrative expense	18.69	4,870.57	4,775.32
Balance at December 31, 1947			$ 75,451.48

(Continued on Page 372)

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SECURITIES
December 31, 1947

	Interest Rate	Maturity	Interest Paid To	Principal Amount or Number of Shares	Cost	Market or Redemption Prices 12-31-47	Income for Year 1947
Bonds held in safekeeping:		Mar. 15-1952-54	Sept. 15-1947	$ 5,000.00	$ 5,129.03	$ 5,156.25	$ 125.00
United States Treasury Bonds	2½%	Aug. 1-1958	Aug. 1-1947	15,300.00	15,300.00	14,963.40	382.50
United States Savings Bonds, Series G	2½%	Aug. 1-1958		1,000.00	742.00	742.00	2.00
United States Savings Bonds, Series F	Note A	June 1-1957	Dec. 1-1947	15,000.00	14,343.75	13,162.50	450.00
Dominion of Canada Sixth Victory Loan Bonds	3 %		Aug. 2-1947				48.89
Bond redeemed in 1947:							
United Light and Power Co.—Note B	5½%				$35,514.78	$34,024.15	$1,008.39
Stocks held in safekeeping:						$ 4,000.00	$ 200.00
Continental Illinois National Bank and Trust Company of Chicago, Illinois, common stock				50 shares 100 shares	$5,250.00 5,175.00	4,087.50	240.00
						$ 8,087.50	$ 440.00
Boston Edison Company, capital stock					$10,425.00		
Bonds held by trustee:				$ 1,000.00	$1,000.00	$ 947.00	$ 25.00
United States Savings Bonds, Series G	2½%	Sept. 1-1955	Sept. 1-1947	8,500.00	8,500.00	8,083.50	212.50
United States Savings Bonds, Series G	2½%	Nov. 1-1956	Nov. 1-1947	5,000.00	5,000.00	4,780.00	125.00
United States Savings Bonds, Series G	2½%	Feb. 1-1957	Aug. 1-1947				
					$14,500.00	$13,810.50	$ 362.50
				TOTAL	$60,439.78	$55,922.15	$1,810.89

Note A—This bond was received as a contribution during the year, and was recorded at its issue price of $740.00. The amount of $742.00 represents redemption price at December 31, 1947, and the amount of $2.00 represents increase in redemption price to December 31, 1947.

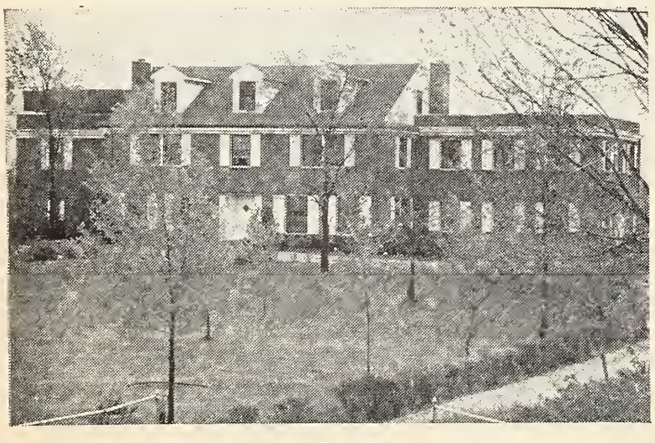
Note B—This bond was called for redemption at August 2, 1947.

COMMENTS

The Michigan Foundation for Medical and Health Education was organized under the laws of the State of Michigan on September 21, 1945, as a corporation, in perpetuity, not for pecuniary profit. The purposes of the Foundation are to acquire, provide, use, develop, endow, and finance methods, means and facilities for postgraduate education in medicine, for education in medicine, for lay health education, and for research, fellowships, and scholarships.

Cash on deposit at December 31, 1947, was confirmed by direct correspondence with the depositary bank.

Included in contribution to the Foundation during the year was a United States Savings Bond, Series F, which was recorded at the issue price of $740.000. A bond having a cost of $925.00 was redeemed during the year, at a profit of $95.00. Securities owned at December 31, 1947, are shown in an accompanying schedule. United States Savings bonds in the principal amount of $14,500.00 were confirmed by direct correspondence with the trustee by whom they are held, and the remaining securities were confirmed by direct correspondence with the bank in which they are in safekeeping. We accounted for the income from the securities for the year.



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The Governors on Health Legislation

A reproduction of Senator H. Alexander Smith's letter of August 7 to the Governors of the States, and an analysis of the replies received from the governors follows:

Senator Smith read this into the record of hearings on S-545 and S-1320 and was challenged by Senator Murray (co-author of the Wagner-Murray-Dingell Bill, S-1320) who stated: "By writing to the governors, you by-pass the people. Why didn't you ask them?" Senator Smith succinctly replied: "The people elect the governors."

August 7, 1947.

"My dear Governor.....:

"One of the most important matters before the present Congress has been the consideration of a national health policy which will bring about a wider medical service to meet the health needs of our people.

"To the end that this subject must be fully investigated, a subcommittee of the Senate Committee on Labor and Public Welfare has been studying the subject for some months. This subcommittee is composed of the following Senators: Senator Ball, Donnell, Pepper, Murray. and myself as Chairman.

"In the course of our investigation and hearings, two fundamentally different approaches to the matter have been presented and considered. These respective approaches are covered by bills that were introduced in the 79th Congress and by bills introduced in the 80th Congress. Extensive hearings were held last year on the Wagner-Murray-Dingell bills which was one of the measures introduced in the 79th Congress. Extensive hearings have been held this year on S-1320 introduced in the 80th Congress by Senator Murray and others, which bill is the successor of the so-called Wagner-Murray-Dingell compulsory health insurance bill, and on S-545 introduced by Senators Taft, Ball, Smith and Donnell.

"Supporters of S-1320 contemplate a nationwide tax collected by payroll deductions of workers in industry and other taxes on non-payroll citizens, in return for which tax the Federal Government assumes responsibility for the over-all medical care of all the people. Provision for certain decentralization of administration is made in the bill.

"S-545, on the other hand, contemplates Federal grants to the several States and challenges the States to develop their own programs for taking care of the health needs of the people within their respective jurisdictions. No special earmarked tax is proposed under the plan.

"Among the important questions which enter into the consideration of bills are:

(1) What percentage of the population in the various States is not getting adequate medical care today; and what classes—that is, the very poor, the white collar class, etc.
(2) What States would approve a compulsory tax plan such as S-1320 calls for, with a Government supervised medical service, or
(3) What States would prefer the S-545 plan, leaving to the States the determination of policy—that is, compulsory or voluntary group health plans, etc.

"Our subcommittee would be very much aided if we could have a statement covering the situation in your State on these matters, which I assume could be prepared by the health authorities. I should add that under either plan Federal grants-in-aid are contemplated. Under S-1320 the Federal tax would cover the entire cost, whereas under S-545 a matching program is contemplated. Copies of S-545 and S-1320 are enclosed.

"Also as related to these problems, I would appreciate information as to the situation in your State with regard to the following matters:

(1) How you handle the health problem in your widely scattered rural areas;
(2) How the new Federal aid-to-hospitals program is working.

"The assistance of our forty-eight States with respect to this important matter will be greatly appreciated, and I hope you can give us an outline of the situation in your State. In making this request I am acting in the spirit of which I understand is the position of the Governor's Conference—a larger participation by the States in the formulation of important national policies."

Always cordially yours,

H. Alexander Smith
Chairman, Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate

Analysis of Replies

Classification	*Number of Governors*
Favors S-545 (with or without qualifications)	25
Favors S-1320	1
No preference indicated	8
Not in favor of either S-545 or S-1320	5
Report not yet submitted	9
Total	48

Identity of the States in the respective classifications is as follows:

Favors S-545

Alabama	Kentucky	North Dakota
Connecticut	Maine	Ohio
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Georgia	Michigan	Pennsylvania
Idaho	Mississippi	Vermont
Illinois	Missouri	West Virginia
Indiana	Montana	Wisconsin
Iowa	Nebraska	Wyoming
	New Hampshire	

Favors S-1320

Utah

No preference indicated

Arizona	New Mexico	Rhode Island
Florida	New York	South Carolina
Louisiana		Washington

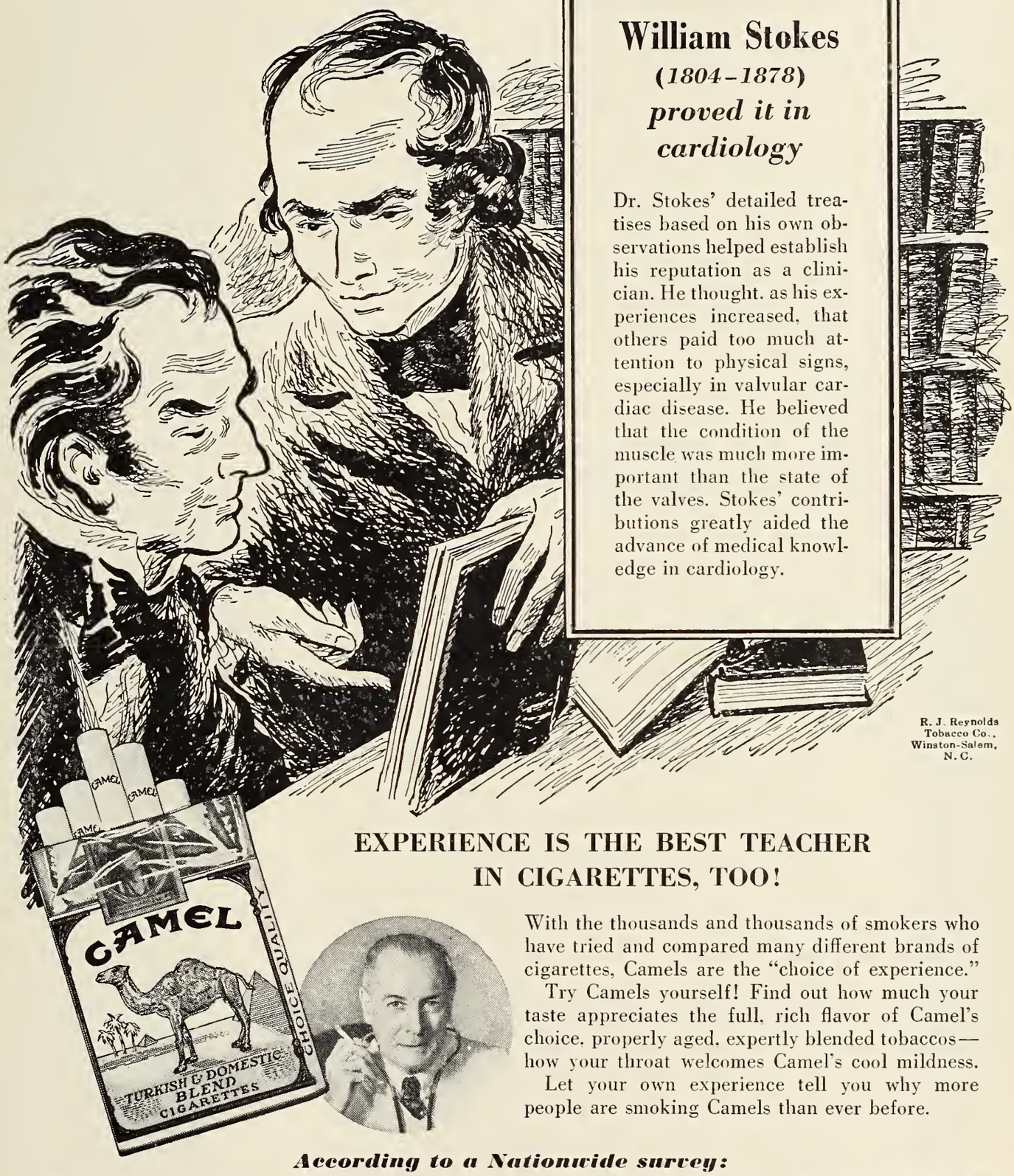
Not in favor of either bill

New Jersey	South Dakota	Tennessee
Oklahoma		Virginia

Report not submitted

Arkansas	Kansas	Nevada
California	Maryland	North Carolina
Colorado	Minnesota	Texas

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Cancer Comment

By the Cancer Control Committee

With this issue THE JOURNAL inaugurates a new page devoted to *Cancer*. Through this medium the State Cancer Control Committee will present material and comment of interest to the profession.

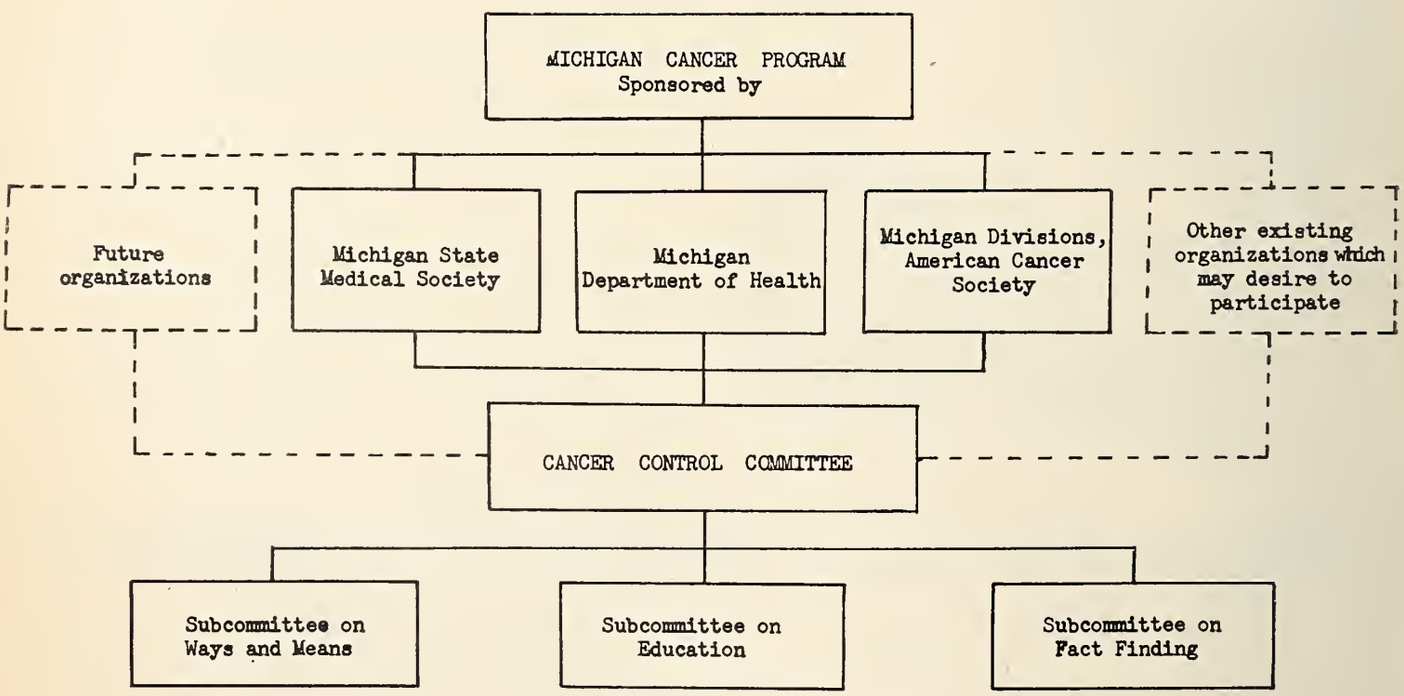
The Cancer Control Committee, with offices at 1313 East Ann Street, Ann Arbor, welcomes this additional opportunity to be of service in the fight against cancer.

In this inaugural venture, a word of explanation regarding the structure and function of the Cancer Control Committee, together with a keynote regarding our most pressing need in achieving success, is in order.

The Cancer Control Committee is sponsored and supported by the Michigan State Medical Society, the Michigan Department of Health, and the two Michigan Divisions of the American Cancer Society. Other State organizations undoubtedly have contributions to make to the work of the Committee and may come to lend their support and active participation in the future (*See* diagram below).

While the Committee has several objectives, such as fact finding and evaluation of existing cancer problems in Michigan, none is more important than functions included under the broad term education. Recognizing the importance of early diagnosis and the necessity for understanding and co-operation between doctor and patient, considerable effort is expended in this direction. The present *Michigan Cancer Bulletin* brings to every physician in the State the latest facts and diagnostic procedures for cancer care. Early diagnosis is emphasized because it continues to be the most important single factor in the control of cancer mortality. However, physicians alone cannot achieve cancer control. Every adult must be convinced of the necessity for periodic physical examination as the best—indeed, at present, the *only* real way of achieving cancer prevention and control.

While educational campaigns have helped to enlighten the public, they are as a mere trickle when compared with what might be accomplished if every physician would undertake to urge periodic check-up for men and women within his sphere of influence. Herein lies an important part of the answer to our cancer problem, and with Michigan physicians lies the opportunity to undertake state-wide, yes, nation-wide leadership. Encourage periodic medical examination by word of mouth and by demonstrating to presumably healthy individuals who desire to remain well that prevention and early diagnosis are mighty good medicine—and available in Michigan.





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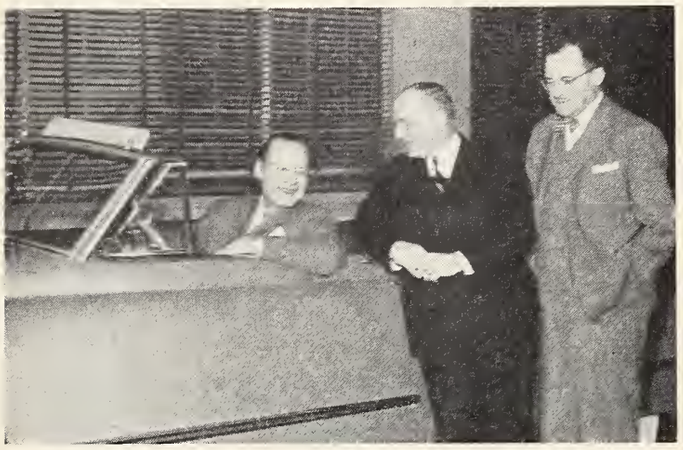
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Industrial In-Plant Medical Meeting

Members of the Ingham County Medical Society were guests of General Motors, Oldsmobile Division, and of its Vice President and General Manager, S. E. Skinner, at a tour of inspection, dinner and medical meeting on February 24, 1948.



GUESTS AND HOST AT OLDSMOBILE IN-PLANT MEDICAL MEETING

(Left to right) O. J. McGillicuddy, M.D., Lansing, President, Ingham County Medical Society; S. E. Skinner, Lansing, General Manager, Oldsmobile Division; Milton Gearing, New Britain, Connecticut, General Manager, New Departure Division, General Motors Corporation.

One hundred and eleven physicians inspected the operations in the plant, and one hundred and sixty attended the dinner, at which S. D. Steiner, M.D., Oldsmobile industrial surgeon, was toastmaster.

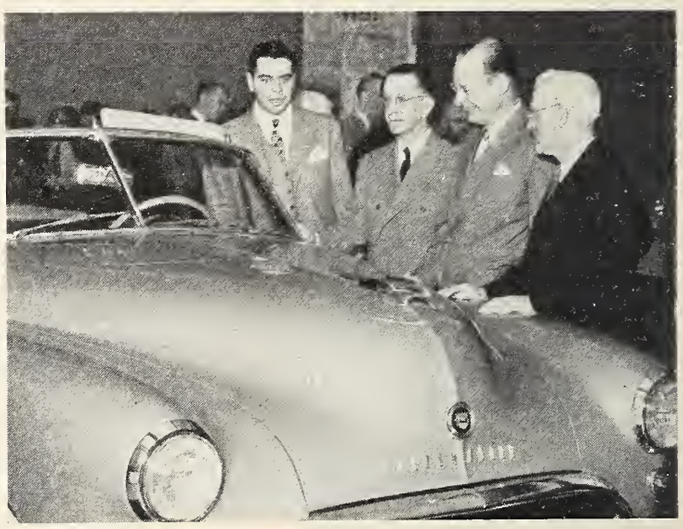
Vice President Skinner welcomed the medical profession of Ingham County and expressed his pleasure that the doctors of medicine were taking time out to investigate the type of work and what "our people—your patients are doing in our plant." He urged a closer alliance between the medical profession and the medical service departments in factories. "We of General Motors want to take this opportunity to thank the doctors of Lansing and Ingham County who have co-operated so wholeheartedly with Oldsmobile and Fisher Body in medical matters affecting our employes," Mr. Skinner said.

C. D. Selby, M.D., Detroit, Chief Medical Consultant for General Motors Corporation, epitomized his enthusiasm for this type of meeting by stating: "We have these men and women for eight hours, and do our best for them in industrial health; you have them for sixteen hours of the day, and their civilian health is your responsibility. We can both work toward twenty-four hours of good health for our workers who are your people."

At the medical meeting, following the dinner, Cole Gibson, M.D., of Meriden, Connecticut, Medical Director of the Undercliff Sanitarium, spoke on "Misdiagnosis in Chest Diseases."

Following the medical presentation, Oldsmobile acted as host for a most interesting stage show.

The thanks of the Ingham County Medical Society was expressed through its president, Oliver B. McGillicuddy, M.D., of Lansing, who credited Oldsmobile's accomplishments to the free enterprise system, as contrasted to government control and planning.



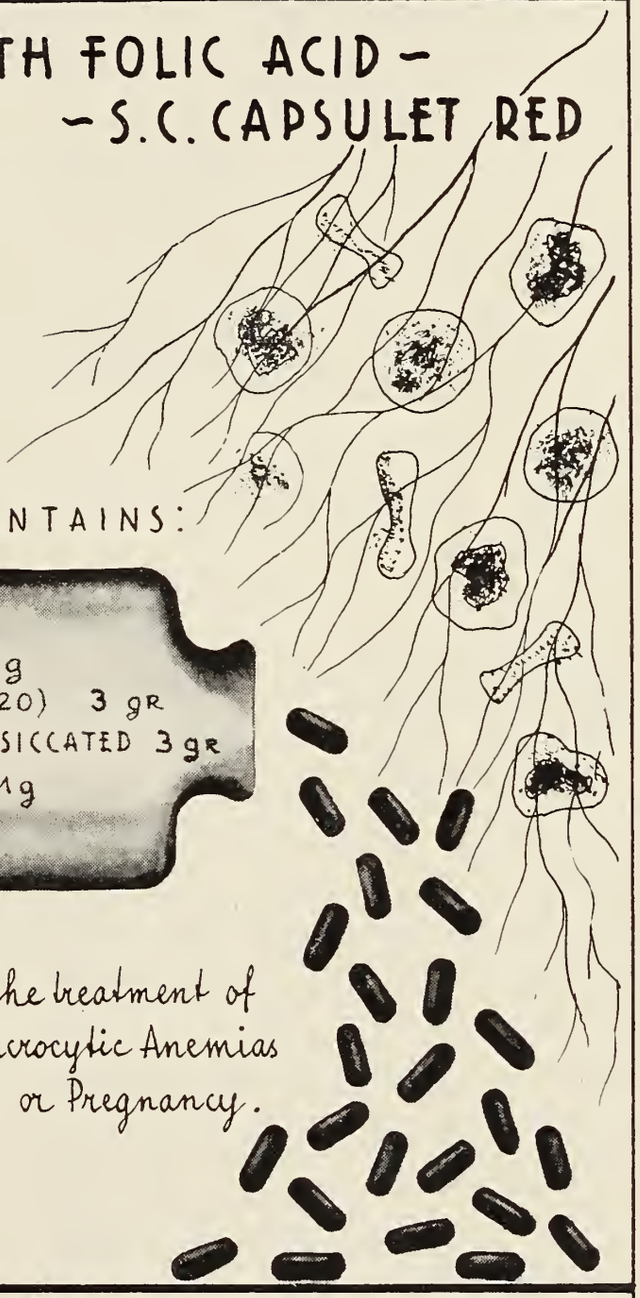
INSPECTING THE "FUTURAMIC" AT INGHAM COUNTY MEDICAL SOCIETY MEETING

(Left to right) S. D. Steiner, M.D., Lansing, Medical Director, Oldsmobile Division; Cole Gibson, M.D., Meriden, Connecticut; O. J. McGillicuddy, M.D., Lansing, President, Ingham County Medical Society; C. D. Selby, M.D., Detroit, Medical Consultant for General Motors Corporation.

Out-of-town guests, in addition to the speakers named, were: Milton Gearing, general manager of New Departure Division, General Motors Corporation, Bristol, Conn.; Peter Rastello, M.D., Ternstedt Division, Detroit; Raymond Van Harm, M.D., Buick Division, Flint; H. J. Krenlen, M.D., Grand Rapids Fisher Body Plant; M. Martinus, M.D., Grand Rapids Diesel Division; A. F. Lichlider, M.D., medical director, Fisher Body; Earl Lutz, M.D., associate medical consultant for General Motors, and Dave Mould, safety director, General Motors Corporation.

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VETERANS ADMINISTRATION RECORDS USED FOR RESEARCH

Medical records of more than 100,000 ill and disabled World War II veterans will be used to aid researchers in their efforts to discover the causes and cures of little-known diseases and unusual injuries, Dr. Paul B. Magnuson, chief medical director of Veterans Administration, said.

Object of the program is to analyze the medical records of such veterans, and through study of the history of their ailments and of the medical treatment given, thus attempt to arrive at sound medical conclusions and recommendations for the care of others who might incur these same disabilities.

The research extends beyond the time veterans are in hospitals to determine causes of relapses and other after-effects suffered in many cases after medical treatment has been given.

The work will cover a wide variety of diseases and injuries.

The projects will be under the supervision of Dr. Edward Harvey Cushing, former associate clinical professor of medicine at Western Reserve University, Cleveland, Ohio, and now chief of VA's Research and Education Service. He will be assisted by Dr. L. G. Welt, formerly an instructor at Yale Medical School and now chief of VA's General Research Section.

This work is being accomplished in co-operation with the Committee on Veterans Medical Problems of the National Research Council, National Academy of Sciences.

VA, individually, or in collaboration with the Research Council, and the Departments of the Army, Navy and Air Force, will determine the specific studies to be conducted.

Contents of all medical records used will be carefully guarded. Before being designated to participate in these clinical studies, physicians other than VA employes, will be required to sign statements pledging they will safeguard the confidential contents of the records reviewed.

While advantages accruing to science and practice will be shared by the medical profession as a whole, VA will be the primary beneficiary of the program.

Some studies will be conducted in VA hospitals by VA physicians or by accredited representatives of the National Research Council. Others will be carried on in the medical schools of outstanding universities.

VA has 35 general research laboratories in operation in hospitals affiliated with Class "A" medical schools. It is hoped ultimately to have such laboratories in all fifty-four VA hospitals which operate in conjunction with medical schools and in some of the other non-affiliated VA hospitals.

In addition, six laboratories for radioisotope research and therapy will be established in 1948 and three more in 1949.

A cardiovascular research unit now is in operation at the VA Mount Alto hospital in Washington, D. C., carrying on extensive studies in relation to heart disease.

Twenty VA hospitals are currently engaged in a broad and thorough investigation of the value and limitations of streptomycin therapy in the various forms of tuberculosis.

More than a half-million dollars in contracts for research into artificial limbs have been awarded to the National Academy of Sciences, various universities and private industries including Northrop Aircraft Corp., which recently released the newly designed "Northrop arm" for distribution to amputees.

Other projects to get under way this year include a study on the value and limitations of vagotomy (severing of nerves leading to the stomach) in the treatment of patients with peptic ulcer whose condition cannot otherwise be improved by medical means, and the evaluation of the usefulness and limitations of proving albumin therapy in liver diseases.

Two centers for an exhaustive study of patients with sarcoidosis (a group of diseases marked by nodular lesions) will be established.

NEW SURGEON GENERAL OF THE U. S. PUBLIC HEALTH SERVICE

Dr. Leonard A. Scheele was born in Fort Wayne, Indiana, July 25, 1907. He received his A.B. from the University of Michigan in 1931; his B.S. in Medicine in 1933 and his M.D. in 1934, both from Wayne University, Detroit, Michigan.

He was commissioned in the U.S. Public Health Service in 1934. His first assignment was as Assistant Quarantine Officer at the Port of San Francisco. He was transferred to the same position in the Port of Honolulu during 1935-1936, then was made Health Officer at Queen Anne's County, Maryland, in 1936-1937.

From 1937 to 1939 he was a Special Fellow at Memorial Hospital, New York.

He was Officer in Charge of the National Cancer Control Program of the National Cancer Institute from 1939 to 1942. In this capacity he was concerned with studies in epidemiology of cancer, in end-results of cancer treatment and liaison with the States and various medical organizations on cancer control. He held the position of Chief, Field Casualty Section, Medical Division, U.S. Office of Civilian Defense in 1942 and 1943.

From 1943 to 1945 he was assigned to the Army in a variety of major assignments in war areas. He served in Military Government and Allied Commission medical operations in Sicily, Italy, and later was in charge of the Preventive Medicine Section of the G-5 Division of Supreme Headquarters of the Allied Expeditionary Force in Northwest Europe. Later he was medical representa-

(Continued on Page 382)



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NEW SURGEON GENERAL

(Continued from Page 380)

tive of the Medical Section of the Allied Control Council in initial operations of that group in Berlin after the surrender of Germany.

Military decorations he received include the American Typhus Medal for his work in the control of that disease in Northwest Europe during 1944-45; the Legion of Merit for outstanding work in controlling communicable diseases in the European Theater of Operations; the Order of Public Health, from France, and several other foreign decorations.

During 1946-1947, Dr. Scheele was Assistant Chief of the National Cancer Institute of the Public Health Service's National Institute of Health. In July of 1947, he became Assistant Surgeon General of the Service and Director of the Cancer Institute.

He is a member of the American Public Health Association and the American Medical Association. He has also been connected with the American Association for the Advancement of Science, American Association for Cancer Research, and the American Public Health Cancer Association.

HEALTH REPORTS FROM FEDERAL SECURITY AGENCY

Read this report—and that was under Voluntary Medicine—not State Medicine—*Imagine This*:

Almost all the States shared in the *general decline in mortality between 1945 and 1946,* according to a statement released by Federal Security Administrator Oscar R. Ewing, summarizing figures of the National Office of Vital Statistics, U.S. Public Health Service. The national crude death rate decreased from 10.6 in 1945 to 10.0 in 1946, and in all but six of the individual States the rates for residents also decreased between these years. Increases were seen for: the District of Columbia (which rose from 9.6 in 1945 to 9.8 in 1946), Florida (from 9.8 to 10.0), Idaho (from 9.4 to 9.7), and Mississippi (from 9.1 to 9.2). New Mexico and South Dakota had the same death rate in both years (10.3 and 10.1, respectively).

All figures shown are for the continental United States and exclude armed forces overseas.

The decreases in the crude death rates were, in large measure, probably due to the large scale demobilization of the armed forces which began late in 1945 and continued in 1946. The return of military personnel increased the population present in the country. However, since these men were in the young adult age groups, for which mortality rates are normally low, they probably contributed relatively little to the number of deaths.

Resident death rates for the States in 1946 ranged from the lowest rate of 7.5 for Utah to the highest rate of 11.7 in Montana, New Hampshire, and Vermont. The corresponding lowest and highest rates in 1945 were 7.9 for Arkansas and 12.4 for New Hampshire.

Crude death rates for residents of five geographic divisions were lower than the national rate in 1946. These divisions were South Atlantic, East South Central, West South Central, Mountain, and Pacific. The crude death rates exceeded the national rate for residents of the other divisions: New England, Middle Atlantic, East North Central, and West North Central. Each of the divisional rates for 1946 were lower than the corresponding rates for 1945.

The number of deaths and death rates for Michigan were 1946, 55,167; 1945, 53,966; and the rates per thousand, 1945, 9.7; and 1946, 9.1.

RURAL MEDICAL CARE PROJECT

Appreciating the need for more doctors of medicine in rural areas, the Michigan Foundation proposes to establish a revolving loan fund to be known as the "Fund for the Encouragement of Medical Practice in Rural Areas." The administration of the program shall be under the direction of a Qualifications Committee. The funds shall be distributed in the form of loans to those students presently in the upper classes of the medical schools, or interns or residents in hospital service, who require financial help.

The requirements of the fund shall be: (a) that the individual obtaining such aid shall be expected to practice in a rural area for a minimum of three years; (b) that the loan shall be without interest until the end of the individual's first year of practice; and (c) that such loan shall be repaid in line with conditions to be established by the Board of Trustees of the Michigan Foundation for Medical and Health Education, Inc.

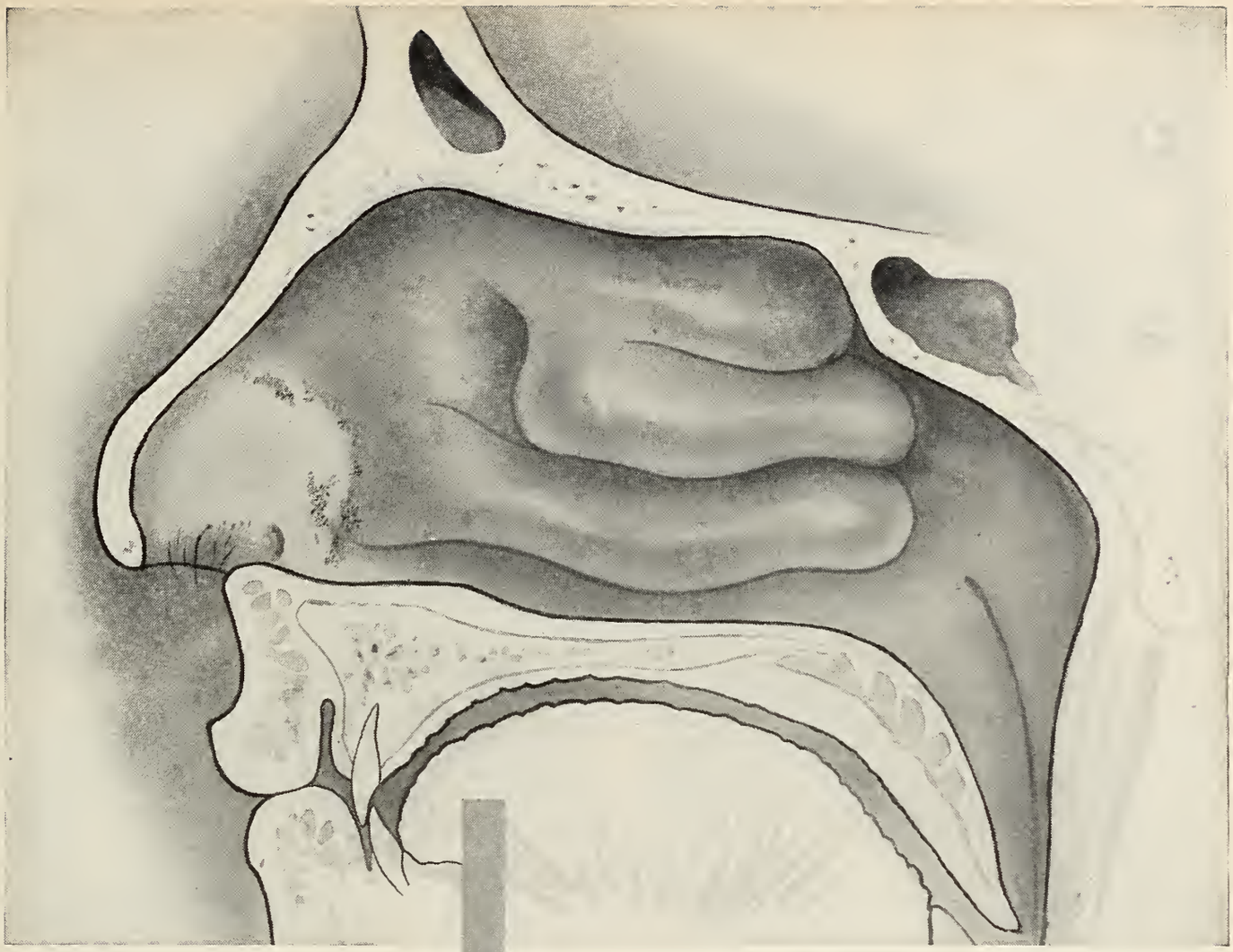
PREVENTIVE MEDICINE GETS INTERIM SPECIALTY BOARD

Consultant and practitioners of preventive medicine, one of the least formalized but most universally important branches of medical science, learned that a great forward step toward professional recognition of their calling as a distinct medical specialty has been made by the formation of an "Interim Board" of Preventive Medicine. Announcement of the move was made jointly by the Surgeons General of the Army, Navy and U. S. Public Health Service.

War and postwar conditions have emphasized the need for uniformly high standards in the field of public health and preventive medicine, and the Interim Board was formed chiefly for the purpose of setting up certification requirements for medical officers seeking to qualify as specialists. The co-operative effort of these three services will undoubtedly give impetus to a growing demand for creation of an American Board of Preventive Medicine and Public Health to take its place along with the 16 medical specialty board already in existence and supply the uniform professional standing and protection specialists need in order to function most effectively.

Members of the Interim Board were selected with great care. Several weeks ago the three Surgeons General formed an advisory committee to consider the problem. Through a pooling of recommendations, a panel was formed of men throughout the country who were con-

(Continued on Page 384)



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PREVENTIVE MEDICINE

(Continued from Page 382)

sidered the most distinguished in the field of public health and preventive medicine. From this panel, six civilian authorities on the specialty were chosen and all accepted an invitation to form the Interim Board. They are: Dr. Ernest L. Stebbins, director of Johns Hopkins University School of Hygiene & Public Health; Dr. Wilton L. Halverson, California State Director of Public Health; Dr. Harry S. Mustard, New York City Health Commissioner; Dr. Thomas Francis, Jr., University of Michigan School of Public Health; Dr. Gaylord W. Anderson, director of the University of Minnesota School of Public Health; and Dr. Hugo Muench, assistant dean, Harvard School of Public Health. Chiefs of the preventive medicine divisions of the Army and Navy and an officer selected by the Surgeon General of the Public Health Service, complete the roster. They are: Dr. James Crabtree, Deputy Surgeon General, U. S. Public Health Service; Colonel Tom F. Whayne, Chief, Preventive Medicine Division, Office of The Surgeon General, U. S. Army, and Captain Otto L. Burton, Chief, Preventive Medicine Division, Bureau of Medicine and Surgery, U. S. Navy.

At its first meeting the Interim Board began drafting a preliminary bill of requirements for certification and elected Dr. Stebbins chairman. Confidence was expressed that official standards for qualification as a specialist in preventive medicine will soon be achieved.

Preventive medicine and public health, although practiced long before most of the other medical disciplines in the form of primitive tribal taboos has lagged behind other branches of medicine in organization and recognition. Today the work of the various groups interested in research and practice in this field is largely uncorrelated. Investigations into industrial and personal hygiene, nutrition, water supply and sewage disposal, mechanisms of disease transmission, pest control, housing and ventilation, and all the other multifarious aspects of preventive medicine and public health, are for the most part carried on independently by many private concerns and various agencies of State and Federal governments. Practitioners in different lines and different areas have no uniform professional qualifications. With its own specialty board and its own professional organization, this field could maintain its integrity and command uniform national recognition. The joint action of the Army, Navy and Public Health Service is a step in this direction.

PUBLIC DEMAND FOR SERVICE AT NIGHT MUST BE MET

The American Medical Association calls on county medical societies to meet the public demand for emergency medical service at night.

"From many sections of the United States," says an editorial in a recent (March 6) issue of *The Journal of The American Medical Association,* "complaints have come lately that persons who have called physicians late at night have been unable to secure attendance from either those whom they considered their family physicians or from specialists or, indeed, from any physicians."

The American Medical Association says that large county medical societies or urban groups should maintain a physicians' telephone exchange which would take the responsibility for locating physicians if response is not made to the ringing of the telephone in the home or in the office.

The solution is simple and practical, requiring only a minimum of community organization. A number of county medical societies already maintain a physicians' telephone exchange where doctors' calls may be received and doctors located if their office or home telephones do not respond. Such an exchange can be utilized as at night or on holidays, simply by furnishing the exchange with a list of physicians who are able and willing to make night calls. Such physicians would probably include the younger general practitioners, newcomers to the community, and others in general practice. If such a roster were available, and its availability widely publicized, night calls for medical service would soon gravitate to this center and the patient would be assured the services of a physician.

Under such a system the necessity for calling many doctors would be eliminated. Two calls at most would be necessary. Where there is no physicians' telephone service, it might be possible to have the hospitals co-operate by handling such night calls.

The Medical Society of the District of Columbia and the Milwaukee County Medical Society have found such a plan practical, as have a number of other societies.

By this simple and practical expedient, which is doubtless in effect in modified form in a number of communities, the sick can be served and the medical profession can redeem its pledge of unselfish public service.

It is highly important that where such arrangements exist they be brought to the attention of the lay people in the community through appropriate public channels, not once but repeatedly, to keep the shifting populations well informed.

Few problems in the field of medical service have aroused so much public discussion. Whether resentment against physicians is justified or not, it does harm. The solution for this problem is so eminently simple and would reflect so favorably upon physician-patient relationships that medical societies everywhere are urged to give it serious consideration immediately.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The general oral and pathology examinations (Part II) for all candidates will be conducted in Washington, D. C., by the American Board of Obstetrics and Gynecology from Sunday, May 16, through Saturday, May 22, 1948. The Shoreham Hotel in Washington will be the headquarters. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Shoreham Hotel.

Candidates for re-examination in Part II must make written application to the Secretary's Office not later than April 1, 1948.

Candidates in military service are requested to keep

(Continued on Page 388)

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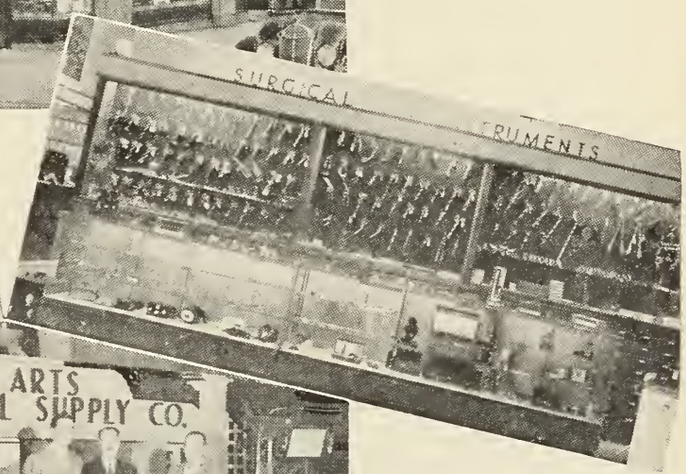
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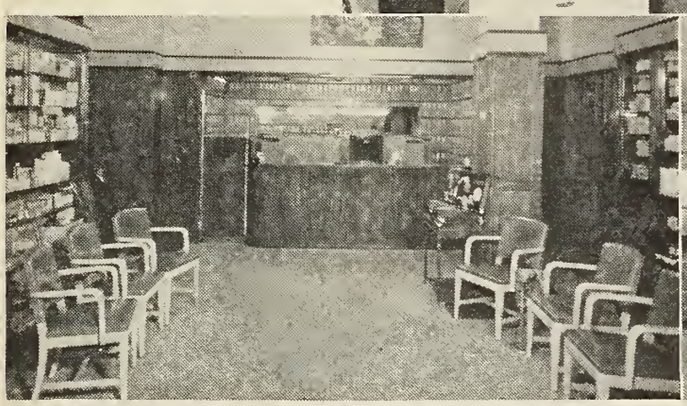






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Political Medicine

NEW LEGISLATION

The gradual extension of government invasion of medicine is shown by new bills in Washington.

S.2189 by Mr. Saltonstall, of Massachusetts, February 20. A Bill to assist the States in the development and maintenance of *local public health units,* and for other purposes.

Referred to the Committee on Labor and Public Welfare. *Comment:* This bill would extend *Federal subsidy* to the States for developing and maintaining local public health units organized to provide basic full-time health services, and to train personnel. The States, in order to participate, would be required to *submit a plan to the Surgeon General* for approval. The Surgeon General shall determine the amount of subsidy and, with the approval of the Federal Security Administrator, *by regulation prescribe*—"(1) criteria for *determining the minimum population* and financial resources which various types of areas must have, and the minimum number and types of full-time professional and other personnel which local public-health units in various types of areas must employ per thousand population, in order to afford reasonable assurance of continued financial support for, and efficient and economical administration of, basic public-health services in such areas; (2) criteria for determining whether *methods for allocating,* under State plans, *the funds* made available under this Act to local public-health units are equitable and such as to assure the effective use of such funds in the provision of basic public-health services; (3) subject to the limits set forth in section 6 (a) (5), general *methods of administration* necessary to assure efficient and economical provision of basic public-health services under State plans, including the conditions under which compliance with such methods may be postponed; (4) *types of health services,* including the training of personnel for local public-health work, which shall be considered basic public-health services for which funds may be expended under State plans."

In order to be approved, the State plan shall: (1) *assure coverage* of all areas in the State; (2) contain saitsfactory evidence that the State health *authority will have authority to carry out* the plan; (3) provide that each local public health unit shall be *assured of continued financial support* and employ a sufficient full-time personnel; (4) assure equitable distribution and effective use of the provided funds; (5) provide for the establishment and maintenance of *personnel standards on a merit basis;* (6) *submit such reports* as the Surgeon General may from time to time require. The Act shall be administered by the Surgeon General under the supervision and direction of the Administrator and for this purpose "the Surgeon General is authorized *to make such administrative regulations* and perform such other functions as he finds necessary to carry out the provisions of the Act."

Tentative drafts of this bill were approved by the State and Territorial Health Officers at a recent conference in Washington and a resolution supporting such legislation was adopted by the National Congress of Parents and Teachers.

S.2215 by Senator Bridges, New Hampshire; Ives, New York; Pepper, Florida; and Murray, Montana, February 25.

A Bill to provide for research and control relating to *diseases of the heart* and circulation.

Referred to the Committee on Labor and Public Welfare.

Comment: This bill is similar to H.R.5087 and H.R. 5159, which were commented upon in Bulletin No. 16. It establishes a National Heart Institute under the Public Health Service and provides for *Federal support* to research and control of diseases of the heart and circulation. The amount to be appropriated to carry out this function has been left up to Congress.

H. Res. 466—Mr. King, California, February 9. A Resolution, instructing the Committee on Interstate and Foreign Commerce of the House, *to formulate, consider, and report to the House of Representatives, appropriate legislation,* authorizing the U. S. Public Health Service *to establish and finance medical scholarships* in recognized medical schools of the U. S., in order to encourage and increase the number of medical school graduates to meet the estimated essential demand for doctors in the various government agencies and the nation at large.

HEARINGS ON S-545 AND S-1320

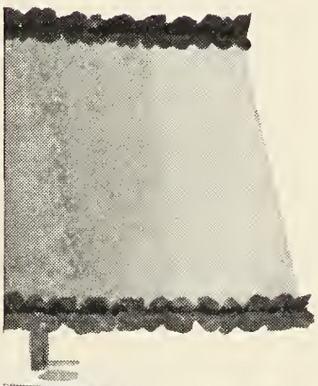
Mr. Isadore S. Falk was the first witness when the hearings were resumed on Tuesday, January 27. He was followed by his assistant, Mr. Wilbur Cohen. By cross-examination, Senator Donnell established for the record the fact that *Mr. Falk* had always been an advocate of compulsory health insurance, and that he did assist Senators and other officials in drafting legislation by supplying them with statistical information. He also admitted assisting Senator Wagner and others in drafting some bills. *Mr. Cohen* was asked particularly about the *Mission to Japan,* and he produced photostatic copies from the Federal Security Agency's files, showing that the concept of a Mission to Japan originated in Japan and the communications were all conducted through the Army offices. The request came from Japan for assistance in the re-establishment of a social security program which they had established more than twenty years ago. Nothing particularly exciting or dramatic occurred in the course of the cross-examination of the two witnesses.

Dr. Friedman, by request, was given an afternoon to refute the accusations made by the Federal Security Agency that the statistics in his previous testimony were incorrect. His refutation was concise and convincing.

(Continued on Page 388)

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PR in Practice

This is an "in-the-meantime" column. Committees meet, plans grow, people work in Public Relations between the time the IDEA is "inkled" —the occasion when the final contract is inked—the date when the project's progress is indicated.

"PR in Practice" will try to keep you informed of some of these "in the meantime" goings-on. The editor sincerely hopes you will enjoy reading this column—the writer makes no claims.

"Tell Me, Doctor"

The Oklahoma State Medical Society has started using the Michigan State Medical Society "Tell Me, Doctor" radio program. The Kanawha Medical Society of West Virginia continues its use. The Medical Society of Virginia, which used it in 1947, will schedule it anew soon. Eighteen Michigan radio stations now carry the program daily. WOAP in Owosso is the latest station in Michigan to join the Society's transcription network—incidentally, the largest of its kind in any state.

Medical Associates

A formal survey to find the exact quantity of Medical Associates needed in the separate fields represented in this "new vocation" is under way. Meanwhile, the Michigan State Medical Society brochure encouraging students to enter these fields nears completion, with layout and writing done. Publication date—the latter part of April. The MSMS Woman's Auxiliary has been invited to aid in its distribution. Facts on the project will be presented to college administrators. At their association meeting in May, they will be formally requested to develop new courses. This is good PR —the schools like it, the students will appreciate it, it will supply a badly needed auxiliary to medicine.

Warning

The technique now being used effectively by proponents of Socialized Medicine is *infiltration.* Pressure has made the workers go underground. Does that sound familiar for their ilk? Watch for these infil-traitors in medical societies and related organizations.

Michigan Health Survey

H. B. Zemmer, M.D., Lapeer, chairman of the Health Survey Advisory Committee, says that top caliber men are being used to assure the accuracy of the Survey which will be conducted by the Social Research Service of Michigan State College. Professor Arnold King of Iowa State University, originator of the technique, top "master sampling" specialist in the United States, traveled to Lansing to advise on procedures and techniques. Questions on the sample will not only give accurate diagnosis of medical needs—but information and public attitudes on knotty questions confronting medicine.

HEARINGS ON S-545 AND S-1320

(Continued from Page 386)

He brought out several new points, and succeeded in making a second real contribution to the material being collected by the hearings.

Dr. Marjorie Shearon began her testimony on Monday, February 2. She submitted a 38-page typewritten statement, almost entirely given over to a discussion of the failure of compulsory health insurance in other countries, and the viciousness of the legislation now before Congress. As she proceeds, reading her statement into the record, she is being extensively cross-examined by Senator Donnell.

Compulsion. Tried. — Last spring, Governor Sigler vetoed a bill passed by the Legislature to compel immunization of school children. The Governor has suggested that the medical profession become more interested in immunization, ostensibly to obviate the need for compulsory legislation in the near future. Medical men know the need for more active work in immunization. The Michigan State Medical Society is heartily in accord with the idea of an immunization campaign and urges all doctors to co-operate fully during February, according to the plan approved by their county (or district) medical society. Contact your society officers for details on the local campaign.

The Voluntary Program Must Succeed.—If the voluntary plan requested by the Governor and urged by both the Michigan State Medical Society and State Health Commissioner Altland should fail, due to inertia or disinterest on the part of our practitioners, then we can expect compulsion by the Legislature, and no later than March, 1948.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

(Continued from Page 384)

the Secretary's Office informed of any change in address.

Applications are now being and will be received until November 1, 1948, for the 1949 examinations. For further information and application blanks, address Paul Titus, M.D., Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

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Cytologic Study of Bronchial Secretions in Diagnosis of Bronchogenic Carcinoma

A Short Review

By Homer M. Smathers, M.D.
Detroit, Michigan



EARLY CANCER detection is at present a much discussed subject. That the physician has not advanced as rapidly as the patient in the common effort, early diagnosis of cancer, is suggested in the recent survey by Leach and Robbins[11] from Memorial Hospital in New York (Table I).

The figures of Pack and Gallo were from the years 1923 to 1938. The latter column represents a survey of 500 cases made in 1946. It is gratifying to note that the incidence of no delay has increased but this increase would seem to have stemmed chiefly from the patient column.

The public has been and must continue to be warned of early signs and symptoms of cancer. Cancer detection centers, together with the mass x-ray program, have been and will continue to be a great aid. The responsibility of the physician, however, to make an early diagnosis of cancer is a serious challenge and he must use every means at his command to arrive at an early diagnosis. The cytologic study of bronchial secretions for diagnosis of pulmonary carcinoma appears to add a valuable mode of diagnosis to the physician's armamentarius. I should like therefore to show the need for this adjunct in the diagnosis of pulmonary carcinoma and to mention some of the work leading to this cell study.

The incidence of bronchogenic carcinoma is said to be between 5 and 10 per cent (Edwards,[6] Weller[17]). Oschner and associates[12] in a very recent article state that pulmonary carcinoma is second in incidence only to that of carcinoma of the stomach. In this same article they reported their experience with 412 cases of pulmonary carcinoma seen during the previous twelve-year period. Of this large series, 60 per cent were considered operable but at exploration only 36 per cent were resectable. Twenty-six per cent survived resection and 8 per cent were alive five years after surgery. The five-year cure percentage will increase as cases are observed for longer periods of time.

TABLE I. DELAY AND CULPABILITY[11]

	Pack and Gallo	Leach and Robbins
Patient alone	44.3%	32.0%
Patient and physician	18.0%	10.8%
Physician alone	17.0%	27.8%
No delay	20.7%	29.4%

The lack of symptoms early in the disease is believed to account for the frequent delay in diagnosis. The most common symptoms presented in this series were cough, loss of weight, pain or discomfort in the chest, a history of previous respiratory infection, hemotysis and dyspnea. The most important factor in the diagnosis is the consideration of its possible presence, especially in anyone over forty years of age. Important diagnostic methods include roentgenography, bronchography, bronchoscopy and cytologic examination of the sputum of bronchial secretions. Other methods include biopsy of nearby nodes and aspiration biopsy of the tumor through the chest wall. This latter method while stressed by Craver,[3]

Presented before the Wayne County Medical Society November 10, 1947.

From the Department of Surgery, Wayne University College of Medicine and the Detroit Receiving Hospital.

TABLE II. MODES OF DIAGNOSIS IN 175 PROVED CASES

	Number	Per Cent
Thoracotomy	8	4.6
Expectorated tissue	0	0.0
Bronchoscopy	80	45.7
Aspiration biopsy from lung	64	36.6
Aspiration biopsy from rib	1	0.57
Lymph node excision	7	4.0
Autopsy	15	8.57

is condemned by others.[12,13] Craver has presented a table (II) of diagnostic methods used at Memorial Hospital from 1918 to 1939. During this period there were 401 cases believed to be pulmonary carcinoma with 175 proved cases.

The possibility of leaving implants along the course of the aspirating needle and the possibility of creating an abscess or empyema have been mentioned, but the only undesired results in Craver's group were two cases of air embolism.

Examination of centrifuged pleural fluid should be mentioned for completeness, but when positive for neoplastic cells, it indicates pleural metastasis and the case is therefore incurable.

Of all of these procedures, perhaps the most controversial is that of cytologic examination of sputum or bronchial secretions. The examination of the sputum for malignant cells originated near the end of the last century with the report of Betschart[2] in 1895 of four cases of malignant disease of the lung in which pieces of tumor were expectorated. Scattered reports appear in the literature until Dudgeon and Patrick[4] revived the study in 1927. In 1935 Dudgeon and Wrigley[5] examined the sputum of fifty-eight cases of suspected pulmonary malignancy and in the subsequently proved cases found 68 per cent positive for malignant cells. These workers used the wet-film method for preparation of the sputum or particles of malignant growth. In this method the sputum is best examined as soon as possible after it has been coughed up or collected during bronchoscopy. Samples are selected with a platinum loop and spread on a slide with immediate immersion in a fixing solution. Following this they are stained with Mayer's hemalum and eosin, then dehydrated with alcohols and xylol and mounted in balsam.

Barrett,[1] in 1938, and Gowar,[8] in 1943, substantiated this method with their own cases and Wandall,[16] in 1944, reported 84 per cent positive sputums for malignant cells in 100 proved cases of pulmonary carcinoma.

In 1946, Herbut and Clerf[9] reported their experience with diagnosis of bronchogenic carcinoma

TABLE III. MALIGNANT CELLS IN 70 POSITIVE CASES[18]

Lesions of upper lobe; bronchoscopic biopsy unobtainable	7
Bronchoscopic negative	7
No bronchoscopic examination	14
Positive bronchoscopic biopsy	41
False positive report	1

TABLE IV

Author	Year	No. of Cases	Source of Material	Per Cent Positive
Seecof & Boetsch[51]	1924	97	Body fluids	70.0
Dudgeon & Wrigley[5]	1935	58	Sputum	68.0
Craver[3]	1940	95	Aspiration tumor	51.6
Gowar[8]	1943	93	Sputum	64.3
Wandall[16]	1944	100	Sputum	84.0
Papanicolaou & Trant[14]	1946	25	Sputum	88.0
Herbut & Clerf[9]	1946	57	Bronchial secretions	82.4
Woolner & McDonald[18]	1947	?	Bronchial secretions	80.0
Gibbon & Herbut[7]	1947	89	Bronchial secretions	86.0

by cytologic study of bronchoscopically removed secretions. They chose bronchial secretion rather than sputum for several reasons. First, sputum is more dilute than bronchial secretions and secondly, expectoration of sputum for malignant cells might arise from any lobe, whereas it is technically possible to ascertain from which lobe secretion is obtained during bronchoscopy. In Ochsner's[12] group of 147 resectable cases, 49 per cent arose from upper lobes where bronchoscopy could neither obtain a biopsy nor see the lesion. The technique of obtaining and examining smears from the upper lobes would therefore seem especially useful. Herbut and Clerf[9] fixed their wet smears in equal parts of 95 per cent alcohol and ether and used the Papanicolaou[14] technique of staining. This technique, first used in the diagnosis of uterine carcinoma, has been accepted and is now receiving the recognition it deserves.

A work similar to that of Herbut and Clerf appeared in September of 1947 from the Mayo Clinic. Woolner and McDonald,[18] using a modified Papanicolaou stain, examined both bronchial secretions and sputum. They feel that the results should be positive for malignant cells in 80 per cent of subsequently proved cases. Table III is taken from their report.

It is of interest that the bronchial secretions revealed malignant cells in every case of positive bronchial biopsy. The one false positive report accentuates the warning of several workers who report false positives in from one to three per cent of examinations. The reasons given for these reports were (a) inexperience in the cytological examination, and (b) inflammatory disease causing cellular changes. All workers state that the false positives occurred in their early studies.

Table IV presents various workers' results in cytologic diagnosis of cancer.

It is of considerable interest that twelve of Wandall's cases were resectable, and of these, ten had positive sputums. Eighty-two of the 100 had bronchoscopic examination and 55 per cent of the eighty-two had positive biopsy. With bronchoscopy and sputum study, 94 per cent were diagnosed positively. In Herbut and Clerf's series, seven cases were positive for carcinomatous cells with negative bronchoscopies. Herbut,[7] in a still more recent report, stated experience with 284 patients from whom 362 specimens were obtained. Eighty-nine of the 284 patients had proved cancer of the lung. Malignant cells were found in seventy-seven of the eighty-nine patients, or eighty-six per cent. There were positive biopsies in only forty cases, or 45 per cent.

In addition to the above workers, Hunter and Richardson[10] have reported excellent results with cytologic diagnosis of bronchial secretions and have stressed several positive results when bronchoscopy was negative. It should be mentioned that most workers suggest examination of at least five smears from each patient before making a negative report. One must bear in mind that a negative finding does not rule out a malignant lesion.

Summary

The cytologic study of bronchial secretions as an adjunct in the diagnosis of bronchogenic carcinoma is emphasized. Recent work by various authors confirms the value of this study in bringing to light cases of bronchogenic carcinoma in which other diagnostic methods have failed.

Conclusion

It is believed that we have a valuable addition to our diagnostic armamentarium, the purpose of which is to bring these patients with pulmonary carcinoma to the surgeon early enough so they are resectable and may possibly be cured.

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Primary Carcinoma of the Lung

Report of 100 Cases

By Nathan Levitt, M.D., C.M.

Detroit, Michigan



THE PURPOSE of this paper is to survey a series of 100 cases of proved bronchogenic carcinoma admitted to Harper Hospital in the period 1942-1947, inclusive.

The diagnosis was confirmed by microscropic examination of tissue obtained from the primary lesion by bronchoscopy, biopsy of metastic lymph nodes, examination of fluid aspirated from the thorax, exploratory thoracotomy or post mortem examination.

Incidence

Whether the increase in the number of cases of bronchogenic carcinoma reported in the literature is real or apparent, is still a debatable question. According to Ackerman and Regato,[1] "The use of more refined diagnostic measures such as roentgenography, radioscopy, tomography, and bronchoscopy has aided the early more frequent diagnosis of carcinoma of the lung. Because it is found primarily in older age groups and as the number of people reaching the upper decades has increased, the incidence of carcinoma of the lung has correspondingly increased."

The evidence for a real increase, however, is brought forward by many other investigators.

In a group of 7,685 consecutive autopsies reported by Koletsky,[10] the lung was the second most frequent site of origin of primary malignant lesions, being exceeded only by the stomach.

Simons[16] has presented evidence of an absolute increase of carcinoma of the lung in England, Canada, Germany and the United States.

Ochsner[12] states, "During the ten-year period ending December 31, 1945, the annual incidence of carcinoma of the stomach, although showing transient changes, remained about the same, whereas the incidence of carcinoma of the lung revealed a steady rise."

From the Department of Internal Medicine, Harper Hospital, Detroit, Michigan.

Berg, Poppe and Havlicek[2] state, "The appearance of the disease in younger individuals can be correlated with the real increase in bronchogenic carcinoma."

In our series of 100 cases at Harper Hospital, the average age was fifty-three and a half years with the extremes being seventy-seven and twenty-nine years (Table I).

TABLE I. AGE AND SEX DISTRIBUTION OF BRONCHOGENIC CARCINOMA

Age, Years	Cases	Male	Female
20-30	2	2	0
30-40	7	5	2
40-50	25	20	5
50-60	36	34	2
60-70	22	16	6
70-80	8	8	0
Total	100	85	15

Etiology

Many investigators have endeavored to establish a connection between bronchogenic carcinoma and chronic irritation of the respiratory tract. Tobacco smoke, air pollution from the exhaust of automobiles, dust raised from tarry roads, have all been suggested as possible causes, but as yet, none of these factors has proven to be the specific cause.

Many attempts have also been made to establish a relationship between the occupation and the incidence of carcinoma of the lung. In an exhaustive article on "Occupational Cancer," Hueper[9] claims, "It appears that the inhalation of radioactive gases or radioactive dust causes cancer of the lung such as that sustained by miners in Schneeberg and Joachimsthal." He further adds "that cancer of the bronchi and lung have been traced to an industrial exposure to arsenicals, chromates, nickel, carbonyl, soot, tar, asbestos and radioactive substances."

It is interesting to note here that in a series of nine cases of pulmonary tuberculosis and bronchogenic carcinoma reported by Gerstyl,[4] four cases gave a history of exposure to silica dust.

Symptoms and Clinical Manifestations

The symptoms of bronchogenic carcinoma depend upon the location and size of the tumor, as well as the secondary changes that occur as a result. In our series of 100 cases of carcinoma of the lung at Harper Hospital, the most common presenting symptoms were cough in 70 per cent of the patients, loss of weight in 35 per cent, chest pain in 30 per cent, hemoptysis in 30 per cent, dyspnea in 24 per cent, weakness in four per cent, wheezing in four and hoarseness in three per cent of the cases.

The onset is often insidious. The majority of our patients gave a history of a pre-existing bronchitis with a change in the character of the cough, from dry to mucoid in character, progressive weakness and extreme loss of weight. About 15 per cent of our patients gave a history of an acute onset. The illness began with an attack of influenza which did not subside in a reasonable length of time. In some of the cases, the onset was ushered in by an attack of pneumonia which did not resolve in the usual period of time.

As a result of these findings, we can state that any patient over forty years of age who gives a history of a chronic cough, which changes from dry to productive, or a history of an acute illness, such as influenza or pneumonia, that does not clear up in the expected period of time, should have a complete checkup including an x-ray of the chest. Should the x-ray show any abnormal findings, a bronchoscopic examination is indicated without delay. The presence of a carcinoma of the lung should be suspected in these cases. Carcinoma of the lung must always be considered in dealing with cases of recurrent pneumonia, bronchiectasis, lung abscess, empyema and pleural effusion.

The duration of time between the onset of symptoms and the diagnosis was seven and one-half months in our series of cases.

According to Moersch and Tinney,[11] "There are three reasons for the delay in diagnosis: (1) the lack of the specificity of the symptoms; (2) failure to suspect the presence of a carcinoma of the bronchus; (3) difficulty in establishing a positive diagnosis even when the condition is suspected."

I believe that there is another reason for this delay in the diagnosis, and that is, although the public is fairly well acquainted with the various signs and symptoms of cancer of the gastrointestinal tract as well as the early signs and symptoms of cancer of the female reproductive organs, they are virtually unaware of the existence of this disease, namely, carcinoma of the lung. It, therefore, follows that the public should be made more conscious of this entity.

Diagnosis

It is a well-known fact that early cases of bronchogenic carcinoma rarely show physical signs. Uncomplicated peripheral tumors may attain a very large size without any signs or symptoms appearing. When the physical signs do appear, they are due to secondary lung changes such as atelectasis, suppuration and pleural involvement.

The physical examination should include a thorough search for the presence of any metastatic lymph nodes. The physical findings suggestive of intrathoracic pathologic conditions were present in 75 per cent of our cases.

Roentgenographic Examination

In 74 per cent of our cases, the x-ray findings correctly suspected the presence of a bronchogenic carcinoma from the films alone. In seven of our patients, the presence of a bronchogenic carcinoma was suspected by the routine x-ray examination of the chest.

Hodges[8] has shown that routine roentgenograms, employed to survey the chests of all patients admitted to the hospital and clinic, can be expected to disclose signs of significant thoracic disease in from 8 to 10 per cent of the group.

In 15,000 patients subjected to routine chest fluoroscopy, Bloch[3] found completely silent intrathoracic neoplasm in ninety-one or 0.6 per cent. Over one quarter of these proved later to be primary bronchogenic carcinoma.

With the increasing routine use of the x-ray in our clinics and industrial mass surveys, we may expect to find more silent intrathoracic neoplasms in the future.

Bronchogenic carcinomas often metastasize to the brain, and cerebral symptoms may often be the patient's only complaint. In our series, eight cases were thought to have metastases to the brain.

Because of these findings, most neurosurgeons advise a routine chest x-ray when a cerebral neoplasm is suspected.

Bronchoscopy

Bronchoscopy is the next most important diagnostic aid. Through this procedure the early diagnosis of bronchogenic carcinoma can be made with great accuracy.

In 75 per cent of the patients in our series, a positive biopsy of the cancer was obtained.

It, therefore, follows that this method of examination should be used in every case where the presence of a pulmonary neoplasm is suspected. In this way, many early cases of carcinoma will be discovered before they reach the stage of inoperability.

A relatively recent diagnostic aid in the early detection of bronchogenic carcinoma is the cytologic examination of the sputum and bronchial secretions. This method is useful in the presence of a lesion in the upper lobes, or because of the peripheral position of the tumor not within the range of bronchoscopic visability and biopsy.

Many investigators, both abroad and in this country, have done extensive research with the cytological examination of the sputum and bronchial excretions in the early detection of carcinoma of the lung. I will not review the extensive literature on the subject in this paper but will give the results of a few investigators.

Clerf and Herbut[5,6] have done extensive research on this method, using the Papanicolaou[13] technique. In a report[7] they state, "In a total of 525 preparations, there were 118 cases of proved carcinoma; cancerous cells were present in the secretions from 105 cases, or 89 per cent; in the same group, a bronchoscopic biopsy was possible in fifty-two cases, or 44 per cent; in an additional twenty-three cases, there was bronchial stenosis, rigidity or distortion; there were, however thirty-two cases, or 27 per cent, in which neoplastic cells were present in secretions and bronchoscopic examination was completely negative. These figures permit only one conclusion. The value of this method of diagnosis in the earlier detection of pulmonary carcinoma is unequivocal."

Woolner and McDonald[17] used a modified form of the Papanicolaou technique in the examination of the sputum and bronchial secretions of 70 patients and arrived at the following conclusion: "Study of malignant cells in sputum and bronchial secretions provides a useful adjunct to already established methods of diagnosis of bronchogenic carcinoma. Such study is especially useful in the presence of lesions of the upper lobe or lesions otherwise inaccessible to the bronchoscope for the obtaining of specimens for biopsy. The method provides a convenient means for establishment of a diagnosis in suspected bronchogenic carcinoma when bronchoscopic examination is contraindicated. A positive result of examination of the sputum or bronchial secretion may be expected in at least 80 per cent of cases of bronchogenic carcinoma. A malignant process situated in any part

of the respiratory tract, or even in the esophagus, may cause carcinoma cells to appear in the sputum. A negative result of cytologic examination does not exclude the possibility of the presence of carcinoma."

According to Meade,[15] in the paper on "The Diagnosis and Operability of Bronchogenic Carcinoma," by Gibbon, Clerf, Herbut and De Tuerk of Philadelphia, it was reported that of 118 proved cases of bronchogenic carcinoma, in only 45 per cent positive bronchoscopic biopsies were obtained. However, by studying by the Papanicolaou technique the stained bronchial secretions, the percentage of correct diognosis was increased to 89. Burford and Wandall of St. Louis reported that a correct diagnosis of carcinoma had been established in twenty-eight or twenty-nine proved cases of carcinoma of the lung just from careful study of the sputum stained with hematoxylin and eosin.

The above studies show that the investigation of the sputum for malignant cells has proved of great diagnostic help. It is of utmost importance that this test be made by one trained in this particular technique. This procedure should be an aid, rather than a substitute for a thorough examination.

Tuberculosis can coexist with carcinoma of the lung. Their condition was found in three cases in our series at Harper Hospital. Gerstyl[4] reported seven cases of coexisting bronchogenic carcinoma and active tuberculosis, since July, 1940, which occurred among approximately 1,600 patients at the Laurel Heights Sanatorium.

Exploratory Thoracotomy

In some cases where a carcinoma of the lung is suspected, from the history, examination and x-ray, but the diagnosis cannot be verified by the usual diagnostic aids, an exploratory thoracotomy should be performed. It is a relatively safe procodure and a sure way of making a positive diagnosis. In our series of patients, eighteen exploratory thoracotomies were performed.

Pathology

Bronchogenic carcinoma is usually divided into three groups: squamous cell carcinoma, adenocarcinoma and undifferentiated carcinoma. Histologically, the tumors were of the squamous cell type in 65 per cent of the cases, the undifferentiated cell type in 25 per cent and the adenocarcinoma type in 10 per cent.

The right bronchial tree was involved in fifty-eight instances and the left in forty-two instances.

TABLE II. METASTASES FOUND AT AUTOPSY

Situation	Incidence
Regional Lymph Nodes	10
Liver	5
Lung and Pleura	6
Adrenal	5
Kidney	2
Ribs	2
Spleen	2
Brain	1
Prostate	1
Esophagus	1
Diaphragm	1
Pericardium	1
Vertebral Bodies	1

Sixteen autopsies were performed (Table II). Regional metastasis occurred in ten cases. Metastases were found in the liver in five cases and in the spleen in two cases. The adrenals were involved in five cases and the kidney in two cases. The pleura and lungs were involved in six cases, the ribs in two cases, and the diaphragm, pericardium, esophagus, brain, prostate and the vertebral bodies in one case each.

Treatment

The present-day treatment of bronchogenic carcinoma consists in the total removal of the lung with the regional lymph nodes. Any other methods, such as radium and deep x-ray therapy, are merely palliative.

In our series of 100 cases, eighteen had an exploratory thoracotomy. Of these cases, seven had pneumonectomy. In four cases, lobectomies were performed.

Radium implantations were instituted in two cases. The rest of the cases received deep x-ray treatments as a palliative measure.

Lately the use of nitrogen mustard, HN_2, has been tried in advanced cases of bronchogenic carcinoma as a palliative measure.

Regarding the use of nitrogen mustard in carcinoma of the lungs, Rhoads[14] states, "Cancer of the lung can be caused to regress in about 50 per cent of the instances. The effects are transient and incomplete."

Summary and Conclusion

From our study of 100 cases of proven bronchogenic carcinoma, we must conclude that the majority of cases of lung cancer are diagnosed too late to do any radical surgery. Perhaps it is due to the fact that this disease masquerades under the disguise of the many commoner chest diseases,

such as bronchitis, pneumonia, tuberculosis, pleurisy, et cetera, that we do not suspect the presence of a pulmonary neoplasm.

Since pneumonectomy is only possible in the early cases, it follows that results will be in direct ratio to diagnosis. In other words, the earlier the diagnosis, the greater the chance for cure.

A good general rule to detect the early cases of bronchogenic carcinoma is to keep it in mind in every case of pulmonary disease in people of the cancer age.

We should use every modern method at our command, such as x-ray, bronchoscopy, exploratory thoracotomy, and the examination of sputum and bronchial secretion by a reliable pathologist, in an attempt to establish the diagnosis.

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MSMS

FEDERAL AID TO STATES

Federal grants in aid to the state were started in 1862, but were only pin money for the first sixty years. During the years 1934 through 1946 these grants totaled over $35 billion. Depression emergency programs accounted for $25,700,000,000. The National Association of Manufacturers' study showed that from fiscal 1924 to fiscal 1930 the federal debt was REDUCED by $6,100,000,000. From 1934 to 1940 it INCREASED $25,900,000,000 in spite of the fact that federal taxes were nearly $17,000,000,000 higher in the second period than in the first.

By comparison the public debts of the forty-eight states increased $1,000,000,000 between 1924 and 1930, and increased only $460,000,000 from 1934 to 1940. In the same period local (city) debts increased $6,400,000,000 and from 1934 to 1940 DECREASED $1,000,000,000.

Sixteen states got nearly six billions of dollars less in federal grants than they paid in taxes earmarked for state aid. Michigan was one of those states, and its "loss" was $343,000,000.

The Diagnosis and Treatment of Breast Tumors

The R. B. Sykes Lecture

By F. A. Coller, M.D.
Ann Arbor, Michigan



BREAST TUMORS must be accurately diagnosed because of the peculiar characteristics of the growth and development of the breast. The breast undergoes four stages of growth. The first is at birth when a few tubules extend into the fibrous base and produce a few drops of "witch's milk." The next stage is the result of intense and continuous bombardment with hormones. This is at puberty, and occurs chiefly in the female but may occur in the male. The breast grows rapidly and mostly uniformly. Any abnormality of growth, rapidity or symetry, should be understood. In the male these growing breasts rarely need attention. In the female they will usually ultimately develop evenly.

The third stage is during pregnancy when the breasts assume a characteristic growth, also controlled by hormone stimulation. Tumors or unusual developments may occur—abscesses, growths, benign cysts, hematomas, lymphatic or glandular irregularities, even malignancies. The fourth period of activity is lactation, which completes the natural development of the breast, and may be complicated by changes which are usually nonmalignant. With a failure of proper growth and stimulation, these changes may be or become cancer. Many women fail in the development stage because they do not nurse their babies, and thus lose this natural stage of development.

R. B. Sykes, D.D.S., in 1947 made a grant to the Michigan State Medical Society for a study of cancer of the breast, to improve diagnosis of the disease, and to disseminate knowledge of this condition to the medical profession. The Council of the Michigan State Medical Society, with Dr. Sykes' consent decided to establish a series of annual lectures by recognized authorities. The first of these lectures was given at the second annual Michigan Postgraduate Clinical Institute, at Detroit, March 10, 1948. The course is named after the donor, and the first lecture was given by Frederick A. Coller, M.D., Professor of Surgery at Ann Arbor. It was a lantern demonstration, not a paper. The above abstract is from the Editor's notes.

A fifth stage is the menopause, a retrogressive process, which due to failure of any kind may not go according to schedule and may produce disease.

At any stage of this life process, something may go wrong. It is the doctor's duty to watch for abnormalities and irregularities. Careful examinations should be made at every opportunity. These may be made in several ways: (1) by inspection at a distance, with the patient seated, looking for irregularities of contour or growth; (2) by palpation with the flat of the hand, looking for nodules, swellings, abnormalities, with the patient lying flat on the back, and then with the patient sitting with arms extended, and then at the sides, looking for axillary and other glands; (3) by transillumination, looking for density changes; (4) by x-rays, looking for breast conditions, but also for lung and bone changes, et cetera, possible metastases.

Lastly, if any condition is found which is not positively diagnosed, it should be aspirated if a cyst, or if a tumor is found, it is the doctor's duty to his patient to make a positive diagnosis—not a guess. A biopsy should be taken and immediately diagnosed by frozed section. This service *must* be available wherever and whenever the biopsy is done, because the choice of conservative or radical operation should depend upon the findings. And the surgeon must be ready to continue his operation as indicated scientifically. If surgery of the breast is involved, it must be properly suited to the case; implemented by complete diagnosis, and only that type of operation done which is found by experience to be most favorable to the patient.

Examinations must be adequate to establish the diagnosis, and treatment be suited to the elimination of the disease if that is possible. Plastic surgery for benign but deforming or handicapping conditions is allowable.

Any abnormal condition of the breast which has continued for only a few weeks without resolution must be thoroughly and completely investigated. Immediate diagnosis must be made at the time tissue is removed.

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We do not have to look for a cure for cancer but for cancers that are curable.

. . .

The fate of the cancer patient rests with the first physician consulted.

. . .

Never forget, cancer is found in all ages.

. . .

Rule out cancer in every diagnosis you make.

The Tuberculous Child

Reflections on Problems of Prophylaxis and Recent Advances in Therapy

By R. V. Platou, M.D.
New Orleans, Louisiana



DURING forty years[40,60] which have elapsed since introduction of practical and precise methods for recognizing early tuberculosis, there have been remarkable changes in its incidence and mortality. Sound public health programs, combining efforts of practicing physicians with those of voluntary and state agencies, indicate that a real hope of evenutally eradicating tuberculosis is now justified;[62] realization depends on increasing facilities for discovering and segregating infectious persons, on furthering our knowledge of specific prophylaxis, and on even greater advances in therapy. Recent encouragement has come from a war-wakened public conscience, from revival of interest in evaluating plans for immunization of selected populations, and from a growing list of publications attesting the apparent efficacy of streptomycin in adjunctive therapy of particular types of tuberculosis for which generally hopeless prognoses are usually made.[45]

Integral in any effective program of case-finding is routine periodic testing of all infants and children. There is no more practical and delicate index to an individual with infectious tuberculosis than the *development* of positive tuberculin reactions among those in his or her environment. For the family of an individual considered to have arrested tuberculosis, this has particular significance; negative reactors in such a situation should be retested frequently, as a means of reassuring the "arrested" individual as well as for their own protection. When exposure to tuberculosis in a child can be traced, the infective source is usually found in the home.[46] For infants, our experience indicates that the usual infectious source is the mother, with previously unrecognized tuberculosis acti-

Presented at the eighty-second annual session of the Michigan State Medical Society, September 24, 1947, Grand Rapids, Michigan.
From the Department of Pediatrics, Tulane University School of Medicine, and Charity Hospital of Louisiana at New Orleans.

vated by the physical and metabolic strains of pregnancy and labor. A common error in prenatal and postpartum clinics is omission of specific measures for recognizing the presence or activity of maternal tuberculosis; these should be carried out routinely, *before* positive cutaneous reactions or other clinical evidences of tuberculosis appear in the infant. Programs for prevention of tuberculosis in children should begin with certification of the homes into which they are coming!

Most of us have had enough experience with tuberculosis in children to agree that a generally benign prognosis for the first infection can only be justified *after* contact with the infecting source has been broken and all evidences of activity have been carefully assayed. I firmly believe and teach that any familiar objective evidences of infection (fever, polynucleosis, increased sedimentation rate of erythrocytes) in a child who reacts positively to tuberculin should be considered due to *tuberculous* activity until proved otherwise. Added rest, more attention to diet, and closer medical supervision until the diagnosis is settled can do no harm; complacency in the face of such warnings too often brooks tragedy. I know of no foolproof criteria by which a benign course can be guaranteed for any individual. The most fulminating clinical forms of tuberculosis are those of infancy and childhood, almost invariably associated with relatively early active primary lesions. Our own concern with the gravity of this problem was recently aggravated when we found that tuberculosis was directly responsible for 6.1 per cent of all deaths among children at our hospital during the past ten years; over 5 per cent of all deaths attributed to tuberculosis occurred in children under twelve years of age.[46] Of the deaths from tuberculosis in children, 75 per cent occurred under age five, and 43 per cent under age two.

Relatively few primary infections produce pulmonary lesions distinctive enough for roentgenologic identification;[57] the majority are so small or so situated as to be inacessible to visualization. Mass surveys by such techniques are, therefore, relatively inefficient as a means of discovering infected children. Routine tuberculin testing for the purpose of selecting those *requiring* careful clinical, roentgenologic, and environmental study is a far more logical plan where infants and children are concerned. For purposes of surveys, intracutaneous (Mantoux) tests are most dependable. If two tests are to be used, the more convenient patch tests[21,58,59] may be substituted for the weaker dilution employed in the first series. Familiar difficulties interfere with reading patch tests often enough so that they are not dependable alone.

Revival of interest in BCG vaccine in this country has awakened many controversial issues and has led to further studies of its limitations and uses. Encouraging reports by Aronson and Palmer,[2] Holm,[33] Ferguson,[20] and others[23,34,50] indicate that the vaccine is safe, and with adequate precautions will play an important preventive role in selected populations. On the other hand, Levine and Sackett,[38] employing alternate controls for a similar study in New York City, found no significant reduction of mortality from tuberculosis among those vaccinated. Because the issue is far from settled, it has been justly recommended that no vaccine should be prepared commercially for use in individual patients at present.[48] It is certainly attractive to believe that any immunity conferred by vaccination may at least reduce the incidence of morbid phenomena associated with the early primary (naturally acquired) infection, and thus perhaps permit consequent more permanent resistance to later re-infection forms.[49] If current studies justify such hopes, vaccination will probably fill a useful function in large-scale programs for control of tuberculosis for at least another generation. In the meantime, separation of infants and children from infectious contacts will continue to be the cornerstone of prophylaxis.

Early experimental observations in treatment with promin and promizole were promising,[1,13,18,19,41,52,54] but clinical experiences with the various sulfones have been disappointing.[7,8,27,31,68] Interest of most clinicians has recently been diverted from these agents by more consistent and dramatic effects of streptomycin in experimental and clinical tuberculosis.[3,4,9,10,12,14-17,24-26,28-30,32,36,43,44,51,63-66] Whereas most patients with miliary or meningeal tuberculosis so far treated with streptomycin have died or demonstrated neuropathic sequelae, many of us have now had our first opportunity to see apparent clinical cures of proved examples in infants and children. Despite relatively minor hazards for patients,[11,39] dangers of resistant strains of organisms following injudicious therapy,[35,42,67] and real fears that our optimism may be premature, early results certainly warrant further evaluation of this most promising agent for early miliary and meningeal tuberculosis. Patients with these lesions have an otherwise poor prognosis and are uniform-

ly resistant to conventional therapy; the same cannot yet be said for many other types of tuberculosis in which prospects for cure by older methods of therapy are relatively excellent.

Even with variations in recorded therapeutic plans, there have already been several apparent recoveries from meningeal and miliary tuberculosis in young subjects treated with streptomycin.[5,6,22,37,47,61] Even among those who did not recover, some showed temporary clinical improvement and the majority presented histopathologic evidences of healing.[3,4,25,28,32,36]

Though adequate data have not yet accumulated to permit authoritative statements regarding *optimal* dosage schedules, a survey of those employed[5,6,22,37,47,61] for patients with a tentatively favorable outcome yields the following information. The total duration of therapy has varied from fifty-seven to 120 days, total dosage from 21 to 120 gm., individual intramuscular injections from 0.01 to 0.3 gm. at intervals of two to three hours. In these infants the total daily dose has been 0.48 to 1.6 gm., and the total daily dose per kilogram of body weight 0.05 to 0.148 gm. Intrathecal streptomycin has been given over periods of fifteen to sixty-seven days, at intervals of twelve to forty-eight hours, in single doses of 0.05 to 0.1 gm. With such large variations among those for whom data were available, it is obvious that there is urgent need for co-operative studies leading to early establishment of plans for effective treatment. Cobley and Goettsch[5] suggested that persistent elevation of the erythrocyte sedimentation rate during treatment with streptomycin might be partially due to multiple inflammatory reactions about injection-sites; this, of course, would interfere with an otherwise useful objective basis for judging clinical progress.

Early in 1945, the work of Smith and McClosky[53] indicated that streptomycin and promin had synergistic effects in experimental tuberculosis; a later communication gave evidence that sulfadiazine did not compare favorably with promin or two other sulfone derivatives tested for such potentiation.[56] Work is still in progress to discover a more effective and less toxic sulfone for such combined therapy.[55]

Until a larger supply of streptomycin is available and more information has accumulated on its uses alone or in combination with various sulfone derivatives, therapy of the tuberculous child must remain essentially symptomatic: rest, while there are any objective clinical evidences of activity, and close medical supervision, at least until healing is evident by all criteria. During this time, changes observed in serial roentgenograms should be compared with alterations in body temperature, total leukocyte and differential counts, and erythrocyte sedimentation rates. In favorable cases, involution and calcification ordinarily take place in about eighteen months.

Summary

Proper periodic examination of infants and children is an integral part of any program for effective case-finding in tuberculosis. For each child who reacts positively to tuberculin, specific studies are indicated, designed to discover source, duration, and site of infection, objective evidences of activity and possible communicability. Symptomatic care, as we now understand it, should be directed by familiar measurable criteria more dependable than those commonly observed in roentgenograms during early years. The course of primary infection in an individual child cannot be predicted with accuracy. Morbid manifestations of tuberculosis in young patients are almost invariably associated closely with the active primary infection. Salvation of those infected depends first and foremost on prevention of re-infection by breaking contact with the original infectious source. Development of a positive skin test in a young child should immediately set in motion a well-planned, vigorous diagnostic and preventive program.

If recent encouraging reports are confirmed, vaccination of selected populations may find an important place in large-scale programs of control. There is urgent need for co-operative clinical study to define more clearly the best method of treatment with streptomycin alone or in combination with sulfone derivatives. Streptomycin appears to be the most practical and effective single therapeutic agent yet directed against the tubercle bacillus.

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A neglected cancer always kills.

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An intelligent interest in cancer is not "cancer phobia."

. . .

One major responsibility of the physician is to allay the patient's fears of cancer.

Mercurial Diuretics in Paroxysmal Nocturnal Dyspnea

By Raymond A. Sokolov, M.D.
Detroit, Michigan

ALTHOUGH MERCURY was known to be a valuable therapeutic agent centuries ago, it is only recently that it has come into its own as a part of our everyday armamentarium in the treatment of the failing heart. With a wider appreciation of its usefulness and a lessened fear of its toxicity has come a general acceptance of mercury as a medicament of merit and safety.

Mercury was employed by Paracelsus in the treatment of edema. William Stokes, in the middle of the nineteenth century, was enchanted by the results achieved in anasarca upon use of mercury.[7] Merbaphen was introduced in 1920 by Saxyl and Heilig,[6] only to be replaced soon after by the less toxic salyrgan. Since then a wide variety of mercurial preparations for parenteral administration have appeared. Batterman has demonstrated the efficacy of orally given mercurial compounds.[2]

The value of mercurial diuretics in cardiac edema is generally understood and is not the subject of this discussion. That these drugs have perhaps greater application in left-sided heart failure is known but has not been adequately stressed. In this latter condition, the patient is confronted with recurring attacks of nocturnal paroxysmal dyspnea. Although the attacks usually respond to the use of morphine or oxygen, or both, such therapy is palliative only, leaving a need for an agent capable of preventing recurrences. Digitalis at times will accomplish this purpose. In many instances, however, digitalis is not enough.

In those cases where the usually accepted regime of digitalis, sedation, rest, weight reduction, and salt restriction is insufficiently effective in staving off the paroxysmal dyspnea, the addition of mercury to the program often yields spectacular results. In the author's experience, this reversal of outlook as to the probability of repeated attacks has occurred so frequently after institution of mercurial diuresis, that he has made it a part of his routine in the prophylaxis of left heart failure. Despite the rare cases of sudden death due to mercurial administration which have been reported in the literature,[1] the benefits to be gained outweigh the risk.

The indications for mercury are not limited to those patients who, in the interval between attacks, show physical evidence of fluid retention, such as hydrothorax or basal râles. It is precisely in those individuals, in whom pulmonary edema must be presumed although it cannot be demonstrated, that this type of diuresis is most warranted. For these are the individuals who have not yet become bedridden, but who ultimately will become so, and can yet be maintained as useful members of society. To wait for physical or roentgen signs of fluid to become manifest before administering mercurials is akin to withholding a diagnosis of poliomyelitis until paralysis is evident.

That pulmonary edema of moderate degree can exist without physical signs is well known. That such occult edema is of more than theoretic importance has been proved over and over in those cases where mercurials have effected profound diuresis and weight loss, with subsequent amelioration of pulmonary symptoms, though pulmonary water-retention was not demonstrable anatomically prior to diuresis.

In this study, forty-seven patients are presented, who manifested evidence of left ventricular failure and, more particularly, paroxysmal nocturnal dyspnea. Table I comprises an analysis of the details of each case. Some of the patients were studied in the hospital; others were seen in the home and in the office. In general, the therapeutic approach has been the same in all of the cases.

The treatment of the individual attack of paroxysmal dyspnea was along conventional lines. Morphine in ¼ to ½ grain doses was given hypodermically, usually in conjunction with 1/100 of a grain of atropine. When indicated, oxygen via tent was also supplied. These measures, unless some other complication was present, or unless the patient was in a terminal condition, were usually adequate to terminate the attack. If the patient had not been previously digitalized, orders were left for rapid digitalization to be completed the following day. At the present time this consists of 1.2 milligrams of digitoxin in twelve hours, to be followed by a daily maintenance dose of .1 to .2 milligrams.

Bed rest was enforced for a varying length of time, in accordance with the patient's progress. If the patient was overweight, a low caloric diet was

TABLE I

	Age	*Sex*	*Diagnosis*	*Treatment*	*Result*
1.	57	M	Old anterior infarct	I.V. mercuhydrin, NH_4Cl	No further attacks; died 21 months later of second infarction.
2.	47	M	Left bundle branch block	I.V. mercuhydrin, NH_4Cl	No further attacks in 14 months since treatment started.
3.	62	M	Hypertensive heart disease, diabetes	I.M. mercuhydrin, NH_4Cl	2 attacks in 8 months as compared with 3 to 4 per week.
4.	47	M	Malignant hypertension	I.V. mercuhydrin	First injection produced shock-like reaction. Treatment abandoned. Death from cerebral accident 2 months later.
5.	59	F	Arteriosclerotic heart disease; old hemiplegia	I.M. mercuhydrin, NH_4Cl	No further attacks in 27 months.
6.	65	F	Arteriosclerotic heart disease; diabetes; calcified gall bladder	I.M. mercuhydrin	No benefit. Death 4 days after cholecystectomy.
7.	58	M	Angina pectoris; coronary sclerosis	I.V. mercuhydrin, NH_4Cl	One attack during first month of therapy, none in past 4 months.
8.	53	M	Left bundle branch block; coronary sclerosis	I.V. mercuhydrin, NH_4Cl	No attacks for 5 months, 3 attacks during first month of treatment.
9.	39	F	Rheumatic heart disease; paroxysmal fibrillation, mitral stenosis	Oral, mercupurin, NH_4Cl	No further attacks in 8 months.
10.	64	M	Arteriosclerotic heart disease	I.V. mercupurin, later I.V. mercuhydrin, NH_4Cl	No attacks for 37 months, discontinued treatment, died 4 months later of acute pulmonary edema.
11.	82	F	Arteriosclerotic heart disease; aortic stenosis	I.V. mercuhydrin	No attacks for 16 months.
12.	55	M	Hypertensive heart disease	I.V. mercuhydrin, NH_4Cl	Attacks continued, patient discontinued treatment.
13.	72	F	Hypertensive heart disease; diabetes	I.V. mercuhydrin, NH_4Cl	No attacks for 7 months; died of cerebral accident.
14.	58	M	Left bundle branch block	I.V. mercuhydrin, NH_4Cl	No attacks for 3 months.
15.	60	F	Rheumatic heart disease, auricular fibrillation	I.V. mercuhydrin	Occasional attack controlled by oral codeine in past 18 months, previously attacks occurred nightly, requiring morphine.
16.	61	F	Arteriosclerotic heart disease; adenoma of thyroid	I.V. mercuhydrin oral mercupurin	Both I.V. and oral medication produced severe diarrhea; treatment abandoned.
17.	59	M	Old posterior infarct	I.M. mercuhydrin, NH_4Cl	Unsuccessful, died 8 days later of acute pulmonary edema.
18.	62	M	Arteriosclerotic heart disease; auricular fibrillation	I.V. mercupurin, later oral mercupurin, NH_4Cl	Four attacks in 29 months, previously bedridden by frequent attacks.
19.	63	M	Hypertensive heart disease; paroxysmal auricular tachycardia	I.V. mercupurin	Improved; only occasional attack for 7 months. Died of bronchopneumonia.
20.	61	M	Hypertensive heart disease	I.V. salyrgan, NH_4Cl	Unimproved, died after 9 weeks of acute pulmonary edema.
21.	57	M	Hypertensive heart disease; extreme obesity	I.V. mercuhydrin, NH_4Cl	No attacks in 7 months, patient discontinued treatment. Died in uremia one year later.
22.	36	F	Rheumatic heart disease; mitral stenosis; aortic regurgitation	I.M. mercuhydrin, NH_4Cl	No attacks for 3 months. Patient lost from study.
23.	86	M	Arteriosclerotic heart disease	I.M. salyrgan, NH_4Cl	One attack in 4 months. Died of gangrene of foot.
24.	66	M	Old posterior infarct; auricular fibrillation	I.M. mercuhydrin	No attacks for 6 weeks. Died of peripheral embolism.
25.	53	F	Hypertensive heart disease	I.V. mercuhydrin	No attacks in 11 months.
26.	57	M	Old infarction, anterior	I.V. salyrgan, NH_4Cl	Occasional attack past 29 months, previously incapacitated by attacks.
27.	72	F	Left bundle branch block	I.V. mercuhydrin, NH_4Cl	No attacks in 43 months.
28.	45	M	Angina pectoris; acute coronary insufficiency	Oral mercupurin, NH_4Cl	No attacks for 8 weeks. Lost from study.
29.	47	M	Malignant hypertension	I.M. mercuhydrin	Unimproved; died of uremia after 11 weeks.
30.	58	M	Rheumatic heart disease; auricular fibrillation	I.V. mercupurin, NH_4Cl	Only 2 attacks in 27 months, both occurring terminally. Died in congestive heart failure.
31.	51	F	Diabetes; arteriosclerotic heart disease	I.V. mercuhydrin, NH_4Cl	One attack in 4 months; previously 2 to 3 per week.
32.	59	M	Old infarction, posterior	I.M. mercuhydrin, NH_4Cl	Died of a new infarction 5 weeks later.
33.	62	F	Arteriosclerotic heart disease	I.V. mercuhydrin, NH_4Cl	Attacks continued; unsuccessful.
34.	67	M	Arteriosclerotic heart disease	Oral mercupurin, NH_4Cl	Occasional attack past 9 months.
35.	64	F	Hypertensive heart disease	I.V. and oral mercupurin	Caused diarrhea, treatment abandoned.
36.	51	M	Intraventricular conduction delay; congestive failure	I.V. mercuhydrin, NH_4Cl	Four attacks in 27 months, previously 7 in 2 weeks.
37.	60	M	Arteriosclerotic heart disease	Oral mercupurin, NH_4Cl	One attack in past 5 months.
38.	55	F	Recent posterior infarction	I.V. mercuhydrin, NH_4Cl	No attacks after first 2 weeks of treatment.
39.	61	M	Hypertensive heart disease	I.V. mercupurin	No attacks for 10 months; died of uremia
40.	56	M	Mitral stenosis, aortic insufficiency rheumatic heart	I.V. mercuhydrin, NH_4Cl	Unsuccessful; died in congestive heart failure.
41.	63	M	Arteriosclerotic heart disease	I.V. salyrgan, NH_4Cl	No attacks in 14 months, after which treatment not effective.
42.	58	F	Old posterior infarct	I.M. mercuhydrin, NH_4Cl	No attacks for 5 months; lost from study.
43.	60	M	Diabetes, angina pectoris	I.V. mercuhydrin	No attacks in 4½ months.
44.	81	F	Arteriosclerotic heart disease	I.V. and I.M. mercuhydrin	Caused syncope; treatment abandoned.
45.	73	M	Left bundle branch block	I.M. mercuhydrin, NH_4Cl	Occasional attack in past 11 months, previously 2 to 3 attacks per week.
46.	71	F	Hypertensive heart disease	I.V. mercuhydrin	No attacks after one month of treatment, for 41 months, then died of anterior infarct.
47.	54	F	Rheumatic heart disease; auricular fibrillation	I.V. mercuhydrin, NH_4Cl	Unsuccessful; died 6 weeks later of pulmonary embolus.

prescribed. Regardless of the patient's weight, a salt-poor regimen was instituted. In a few instances we have attempted to enforce a low sodium diet as advocated by Grollman,[3] but we have found few patients willing to adhere to this diet for any length of time. Sedatives and restriction of physical activities were almost always ordered.

In the earlier cases, no mercurial was used unless the above measures failed to eliminate all signs of pulmonary edema or failed to prevent recurrences of cardiac asthma. Later it became evident that many of these patients ultimately required more energetic diuresis, so that mercurial diuresis was made an integral part of the treatment in all cases where no contraindication existed.

It has been shown that acidifying agents, such as ammonium chloride, enhance the diuretic effect of the mercurials. Modell found that the degree of enhancement is only about 15 per cent.[4] This difference is frequently not clinically significant, so that adequate diuresis may be obtained without coincident acidification. Where patients have objected to the gastrointestinal side effects of ammonium chloride, we have not insisted upon its use. When well tolerated, the prescribed dose is 9 grams per day for two or three days prior to administration of the mercurial.

The mercurial diuretic used in this study was mercuhydrin.[5] This agent does not produce renal injury and is less irritant than mercupurin when given by intramusculuar injection or when it is inadvertently given around a vein through faulty technique. It is fully as effective as mercupurin.[5]

The first dose of mercuhydrin is 1 c.c. intravenously. This is followed in four days by a 2 c.c. dose. Thereafter injections of 2 c.c. are given once a week until the patient is considered stabilized. At this point the interval between injections is lengthened as much as possible, the limiting factor being the return of symptoms. In our experience, this interval is subject to great variations in different patients, ranging from four days to four weeks. The intramuscular route is equally as effective as the intravenous route, and was frequently employed in this series. Rectal administration was found to be too unpredictable and was abandoned. The oral route was used in a few patients, but experience with it is as yet limited.

Mercurials should not be given in the presence of severe kidney disease, in severely dehydrated patients or those with depleted serum chlorides, in the moribund, in the presence of shock associated with recent myocardial infarction, in patients having previously exhibited idiosyncracy to the drug, and in the presence of large amounts of digitalis-containing edema fluid.

Several case histories, illustrating the technique described above, follow.

Case Reports

Case 1.—L. R., a white woman, aged eighty-two, first noted nocturnal dyspnea at the age of seventy. Recurrences were infrequent until at the age of seventy-six they began to occur every night. She was hospitalized in another city, where digitalis and aminophyllin were prescribed. Under this medication the patient was comfortable for a period of eight months, after which time she again began to experience attacks of cardiac asthma. The attacks failed to subside in spite of long periods of bed rest at home and in the hospital. When first seen this patient was receiving digitalis, aminophyllin, phenobarbital, and was largely confined to bed. She was receiving frequent injections of aminophyllin intravenously for relief of dyspnea and morphine injections two or three times per week.

Examination revealed a well-nourished elderly woman lying quietly in bed. No cyanosis or edema was present. Blood pressure was 176/108, pulse 88, respiration 22. The Fundi showed Grade II retinitis. The heart was enlarged to the left anterior axillary line. There was a harsh systolic murmur at the apex and a rough systolic murmur in the aortic area, transmitted to the neck vessels. A thrill was felt over the upper sternum. An occasional moist râle was heard at the right base; otherwise the lungs were clear. The electrocardiogram showed left ventricular strain and serious myocardial damage. The chest ray revealed an enlarged heart and a calcified aortic valve. The urine showed a trace of albumin and 10 to 15 white blood cells per high-powered field.

The clinical diagnosis was arteriosclerotic heart disease, aortic stenosis, and left ventricular failure. No change was made in the patient's medication except that intravenous mercuhydrin was given every fourth day. Because nausea was present at the outset, ammonium chloride was not used. Since then it has not been found necessary to prescribe it. This patient has now been under observation for sixteen months, having had approximately 110 injections of mercuhydrin. She has had not one attack of nocturnal dyspnea, is ambulatory, and, for her age, is self-sufficient.

Discussion.—This is the case of a woman of advanced age, who had recevied very adequate treatment for a failing heart, but who remained, in spite of treatment, a bed-ridden invalid. When mercuhydrin was administered she became free of attacks of nocturnal dyspnea and was able to be ambulatory. This case demonstrates also that advanced age is not in itself a contraindication to prolonged mercurial therapy. An additional feature of this case history is the good result obtained despite the fact that ammonium chloride was not used.

Case 2.—R. L., a white woman, aged thirty-nine, had rheumatic fever at the age of six and was diagnosed as having mitral stenosis at the age of twenty. Upon admission to the hospital, it was learned that she had been receiving digitalis and quinidine for at least six years for attacks of nocturnal wheezing and dyspnea and attacks of paroxysmal auricular fibrillation, the two types of attacks not necessarily occurring simultaneously. One or both types of attacks had been occurring at least once a month for the past two years.

Examination revealed a moderately enlarged heart with the typical findings of mitral stenosis and insufficiency. The rhythm was normal. The lung fields revealed a few basal râles. No dyspnea, cyanosis, or edema was present.

A maintenance dose of .1 milligram daily of digitoxin was continued, as was a prophylactic dose of 3 grains of quinidine three times daily. In addition, and for the first time, the patient received ammonium chloride, 9 grams daily for three days, followed by an intramuscular injection of 1 c.c. of mercuhydrin. This resulted in a urinary output of 3,900 c.c. in the ensuing twenty-four-hour period. Since the patient weighed only 98 pounds, this constituted a very adequate diuresis. One week later mercupurin tablets were substituted for parenteral mercuhydrin, at the rate of three tablets a day for three days. When it was apparent that the patient was tolerating her medication well, she was discharged from the hospital. To date, eight months after discharge, there has been no recurrence of either the nocturnal dyspnea or the paroxysmal fibrillation. The mercupurin is being administered every two weeks.

Discussion.—This is an example of left heart failure in a case of rheumatic heart disease. Paroxysmal dyspnea remained a problem in spite of digitalis. Mercuhydrin was the solution to the problem. In this instance, orally administered mercuprin was used and was entirely adequate.

Case 3.—W. B., a white man, aged fifty-three, on admission to the hospital gave a history of repeated attacks of paroxysmal nocturnal dyspnea over a period of only six months, necessitating hospitalization four times in various other hospitals. He had been digitalized, but had had no mercurial injections.

The presenting picture was quite typical of an attack of cardiac asthma, with orthopnea, cyanosis, and generalized pulmonary râles. The attack responded to morphine. Subsequent investigation revealed that the heart was enlarged to a point just medial to the anterior axillary line in the sixth intercostal space. There was a systolic apical murmur. Basal râles were present bilaterally. The liver edge was palpable three finger-breadths beneath the right costal margin.

An orthodiagram showed the heart to be enlarged 15 per cent above the normal. The electrocardiogram provided a diagnosis of left bundle branch block and severe myocardial damage.

Digitalization was resumed. Additional therapy consisted of a salt-poor acid-ash diet and theominal, three tablets daily. Good diuresis was attained upon the administration of 6 grams of ammonium chloride for three days, followed by 2 c.c. of mercuhydrin by vein. On the eighth hospital day the patient was discharged.

At two-week intervals since discharge from the hospital, ammonium chloride in the same dose has been repeated. After three days of this drug, 2 c.c. of mercupurin were administered intravenously in the office. Theominal, digitoxin, and a salt-poor diet have been maintained. On this regime the patient has remained entirely free of nocturnal dyspnea and has been able to return to full-time employment as an inspector in an auto plant. Fourteen months have now elapsed without incident.

Discussion.—This is an additional example of nocturnal dyspnea which recurred in spite of adequate digitalization, diet, et cetera. With the periodic diuresis obtained as a result of mercuhydrin administration, no further attacks of dyspnea have occurred.

Case 4.—S. W., a white woman, aged sixty-five, entered the hospital with a history of known diabetes, requiring insulin for thirty years, and known hypertension for ten years. For several months prior to admission she had been suffering from attacks of dyspnea, occurring during the late evening and at night. These attacks had necessitated two hospitalizations elsewhere.

For six weeks prior to this admission the patient had been receiving intramuscular injections of mercuhydrin at weekly intervals at home. Since the patient had been complaining of nausea, ammonium chloride was not given. In spite of the injections, the patient had a severe attack of dyspnea one night, along with severe vomiting and right upper quadrant pain. It was then that hospitalization took place.

Examination revealed a moderately enlarged heart and a soft blowing systolic murmur in the aortic region. There were moist râles in both lung field bases. Radiographic examination showed in addition a small amount of fluid at each lung base. The electrocardiogram indicated delayed intraventricular conduction and serious myocardial damage.

In the hospital the lung fields cleared and the heart became fairly well stabilized. The diabetes was controlled. Roentgen studies revealed a large calcified gall bladder. It was felt that the pathologic gall bladder had been responsible for a great deal of postprandial discomfort, which in turn had helped bring on the cardiac attacks. In spite of the great risk a cholecystectomy was decided upon. A large grapefruit-sized gall bladder was removed. Its wall was stony hard and its interior filled with thick inspissated pus. The postoperative course was very stormy, and on the fourth day after operation the patient had a sudden attack of ventricular fibrillation and died within a few minutes.

Discussion.—In this case there was no benefit from the administration of mercuhydrin. It was felt that the mercury which the patient had received played no part in her ultimate postoperative death.

Case 5.—L. M., a white man, aged forty-seven, when first seen stated that he had been told six months previously that he had malignant hypertension. His family physician had referred him to a neurosurgeon for splanchnicectomy. However, operation was not attempted because the disease was too far advanced. During the previous month the patient had had two incidents of nocturnal dyspnea requiring morphine for relief.

Examination in the office revealed a blood pressure of 242/160 in the left arm. The fundi showed marked papilledema, with old and new hemorrhages. The heart was enlarged to the anterior axillary line in the fifth interspace. A harsh systolic murmur localized to the apical area was heard. There was a diastolic gallop rhythm present at the apex. The lungs were clear. No peripheral edema was present.

The urine contained 2-plus albumin and an occasional granular cast. Nonprotein nitrogen was 42 milligrams per cent. The electrocardiogram revealed marked left ventricular strain and delayed intraventricular conduction.

In spite of the poor prognosis, it was decided to attempt mercurial therapy in the hope of averting further attacks of nocturnal dyspnea. Auxiliary treatment consisted of low sodium diet, barbiturates, and aminophyllin. Ammonium chloride was not employed.

The intravenous injection of 1 c.c. of mercuhydrin produced in the patient a state of semi-shock about three hours after the injection. The skin became pale and clammy. The pulse was rapid and thready. The blood pressure dropped to 144/122. The patient was weak, drowsy, and apathetic. After forcing fluids, there was partial recovery. It was three days before the patient reverted to his usual state. Mercurials were not again attempted. It was later learned that this patient subsequently went to live on his father's farm and died two months afterward of hemiplegia.

Discussion.—This case illustrates the danger in using mercurials in the obviously moribund patient. It also demonstrates a picture occasionally encountered when a mercurial diuretic is administered to a dehydrated patient.

Summary

1. A routine of management is presented which useful in preventing attacks of paroxysmal nocturnal dyspnea in patients with left-sided cardiac failure. Although this form of treatment is not new, its value has perhaps been emphasized inadequately.

2. Forty-seven cases are described in tabular form, in which a mercurial diuretic was used with the purpose of minimizing the frequency of paroxysmal nocturnal dyspnea. In many instances the results were favorable. In some they were not. No

(Continued on Page 451)

Proctologic Principles in Hemorrhoidectomy

By J. F. Wenzel, M.D., F.A.C.S.
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A GOOD hemorrhoidectomy entails three things: (1) sigmoidoscopic examination, (2) complete removal of pathological tissue, and (3) avoidance of postoperative complications.

Sigmoidoscopic Examination.—The treatment of hemorrhoids in the presence of an undiscovered carcinoma of the rectum or sigmoid remains a sad phase of medical practice. Carcinoma, in obstructing the superior hemorrhoidal vein, is often an etiological agent in the production of hemorrhoids. Sigmoidoscopic examination is the one accurate method of ruling out the presence of carcinoma. Barium enema examination is helpful, but an early lesion in the rectum or rectosigmoid is often obscure.

Complete Removal of Pathological Tissue.—Recurrence of hemorrhoids frequently is due to incomplete removal of pathological tissue. A minimal hemorrhoidectomy, in which only gross hemorrhoidal masses are removed, produces a minimum of postoperative distress and assures rapid healing, but the recurrence rate is proportionately high if "small" hemorrhoids remain to become "large" hemorrhoids at a later date. One hemorrhoidectomy should be sufficient for any one individual. Pathological tissue should be submitted to the pathologist; examination will be rewarded by the occasional discovery of malignancy.

Avoidance of Postoperative Complications.—*Anal ulcer* often follows when internal wounds are not drained beyond the anocutaneous line. Incompletely drained hemorrhoidectomy wounds suffer contamination and erosion of the operative bed into the sphincter muscle, with irritation of exposed sensory nerve endings. Lack of healing and severe knife-like pain result.

Anal fistula following hemorrhoidectomy is the price of inadequate postoperative care. With the cessation of anesthesia, the sphincter contracts,

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closing the anus and approximating the hemorrhoidectomy wounds. The approximated anocutaneous junction unites quickly before the deeper tissue has granulated or healed. Secondary infection occurs at the internal wound, invades the unhealed deeper tissue under the bridge of the approximated anocutaneous junction and an immediate postoperative fistula results. Digital examinations are helpful in keeping wound edges separated until granulation fills the deeper recesses.

Abscess occurs following the use of stab ties to control bleeding points following side-to-side suturing of wounds to "cover" raw areas, and as a complication to postoperative ulcer and fistula.

Ano-rectal strictures are of three types: high, low, and anal stenosis. (1) High stricture is produced by too wide ligation of each hemorrhoid at the superior pole, with a resulting "purse-string" above the anorectal line. (2) Low stricture results from the excision of internal and external hemorrhoids *en masse;* the widest point of excision occurs at the anocutaneous line. Stricture occurs at this level by scar tissue formation and subsequent contraction at the widest portion of the wound, the anocutaneous line. (3) Anal stenosis is due to denudation and resultant fibrotic contraction of the whole anal canal. Adequate strips of anal lining must remain between each wound.

Incontinence occurs if the sphincter muscle is included in the excision of hemorrhoids or if the muscle is improperly incised to prevent postoperative spasm.

Hemorrhage may be immediate or delayed. The blood supply is controlled by catgut ligation at the superior pole of each hemorrhoid. Other than this, only arterial spurters need be ligated. Oozing from the bed of the wound may be controlled by the use of oxycel gauze. The use of multiple catgut stab ties to procure absolute hemostasis is unnecessary and time consuming, produces pain and spasm by inclusion of muscle and nerve endings, and may introduce infection into deep tissues.

Dangerous hemorrhage within the first twenty-four hours is usually the result of a primary ligature slipping from the superior pole of the hemorrhoid. At the conclusion of the operation, the main ligature at the superior pole should be examined; if secure, there is no need for a drain in the anal canal.

Delayed hemorrhage may occur as late as two weeks postoperatively, particularly in the arteriosclerotic patient.

The foregoing principles are combined in the "Composite Technique of Hemorrhoidectomy,"

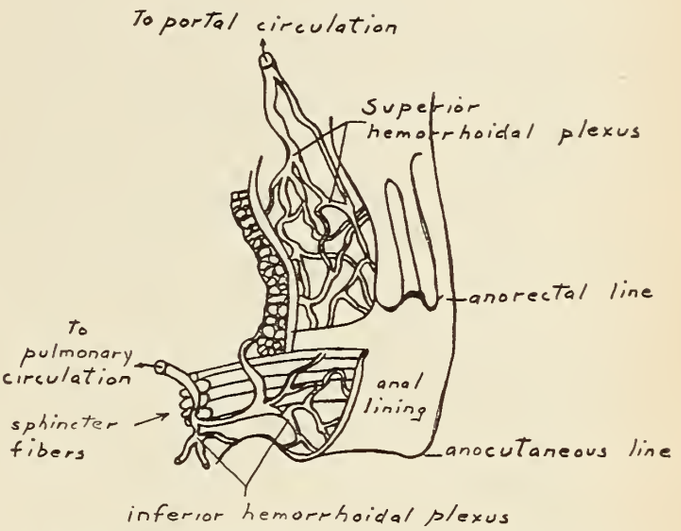


Fig. 1. Position of internal and external hemorrhoids. See text for discussion. After a dissection by H. E. Bacon.[1]

first described by Dr. E. G. Martin in 1920[2] and subsequently modified to include the use of plastic flaps.[3] An outline, related to the illustrations, follows.

Figure 1

The anastomosis of the superior, middle, and inferior hemorrhoidal veins forms a plexus at each of two levels:

1. Above the anorectal line. When these venules engorge, internal hemorrhoids result.
2. Beneath the anocutaneous line. When these venules engorge, usually secondary to the internal group, external hemorrhoids result.

Plexus engorgment occurs at three classical areas: the right anterior, the right posterior, and the left lateral. Other areas of engorgment are usually branches from one of these three.

Surgical removal should follow the anatomy and deal with the internal group separately from the external.

Figure 2

1. Excision of internal hemorrhoid: The ligature at the superior pole controls the blood supply. Inclusion of an expanse of tissue is avoided to prevent a "purse-string" of the rectal mucosa, with a

resultant high immediate stricture. Deep insertion into muscle tissue is also avoided.

Redundant pathological tissue is removed down to the thin layer of fascia covering the sphincter.

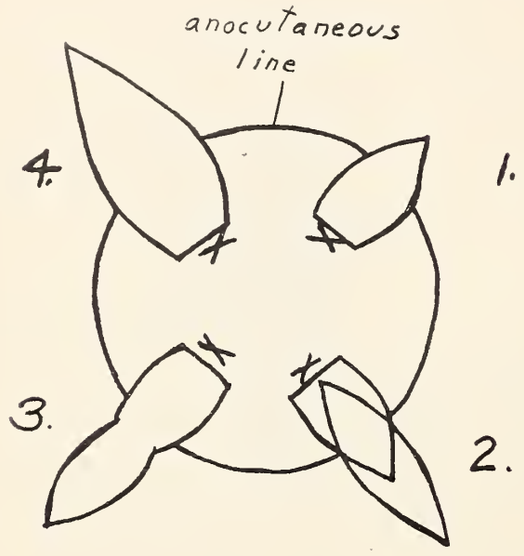


Fig. 2. Operative removal of hemorrhoids. See text for discussion.

The wound is tapered beyond the anocutaneous line to prevent postoperative ulcer.

2. Excision of external hemorrhoid: The wound is tapered to the outside for better drainage. It meets the internal hemorrhoidal wound to form an hour-glass shape at the anocutaneous line, thereby conserving maximum tissue at this line.

3. Final wound shows the hour-glass at the anocutaneous line. Digital examinations must be done periodically to keep the edges at this point from uniting before the depth of the wound has healed, or a fistula may result. The wound is left apart for drainage; suture of the wound invites abscess formation.

4. The elliptical type of excision of both internal and external hemorrhoids in one stage, shows the maximal removal of tissue at the anocutaneous line. If this is applied to all areas, scar tissue contracture results in a low stricture at the anocutaneous line.

Figure 3

1. Accessory hemorrhoid involving a strip of anal lining between two hemorrhoidal wounds. This strip of anal lining must be preserved to prevent postoperative anal contracture.

2. Transverse excision of a narrow section of lining overlying a large accessory hemorrhoid. The hemorrhoidal venules are evacuated. The exclusion is planned so that the ends can be re-united without tension.

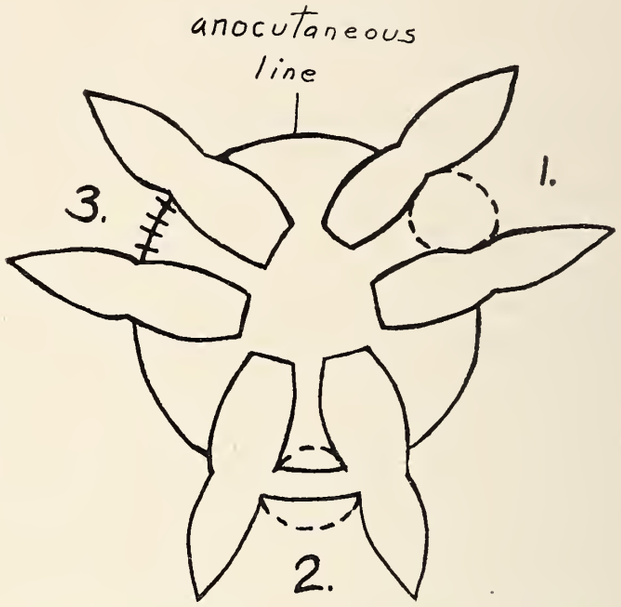


Fig. 3. Operative removal of accessory or intervening hemorrhoid. See text for discussion.

3. Ends of the transverse wound are sutured with 00 chromic catgut, conserving the anal lining between the main hemorrhoidal wounds to prevent postoperative contracture of the anal canal.

Conclusion

An adequate hemorrhoidectomy, employing the principles of proctologic surgery, implies sigmoidoscopic examination, the complete removal of pathological tissue, and the prevention of postoperative ulcer, fistula, abscess, stricture, hemorrhage, and incontinence.

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MSMS

Every cancer death has fear and ignorance as a contributing cause.

. . .

Making light of a patient's questions will not diagnose cancer.

. . .

A "watchful waiting" attitude never diagnosed cancer.

. . .

Conservative treatment conserves the cancer but not the patient.

Potentialities and Limitations of Prenatal Pediatrics

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IN ORDER TO define the need for "prenatal pediatrics," I should like to point out that of every 1,000 viable fetuses *in utero,* between forty and fifty will not be alive at two weeks after the expected date of birth. Let us call this entire group "fetal losses," for want of a better term. About half of these fetal losses will be neonatal deaths among live-born infants; the other half will be stillbirths. There is a natural tendency for these stillborn infants to be written off as acts of God—at least by the pediatricians—but this is certainly failing to meet a medical responsibility. A pregnancy terminating in stillbirth is almost as tragic for the parents as one terminating in a neonatal death. Dr. Irving has expressed this with his usual force by saying, "A woman doesn't come to the Lying-in Hospital to undergo a case of pregnancy. She comes to take home a baby."

Now, the possible prevention of these fetal losses, whether neonatal deaths or stillbirths, is largely in the realm of what a recent British speaker[10] has called antenatal or "prenatal pediatrics." In this area, too, must be considered attempts to increase resistance to infections and other diseases in early life. Finally, whatever can be done to prevent unfortunate congenital conditions not causing early death but jeopardizing the child's later life—such as malformations and the results of birth trauma and anoxia—might also be considered under prenatal pediatrics.

It should at once be understood that this term in no sense implies unwarranted and uninvited invasion of the obstetrician's field by the pediatrician or by anyone else. I use it simply to imply that in the future an increasing amount of medical effort may be directed at the child between conception and the beginning of his extra-uterine life. The interest of all of us should be allied in this field, just as the orthopedist, the pediatrician and the immunologist must and do join forces for the most profitable attack on the poliomyelitis problem.

I believe there is, then, a field for prenatal pediatrics. Recent developments have stimulated much interest and many hopes (some of them as yet unwarranted) for the results of cultivation of this field. In the light of present knowledge, what can be expected?

Let us first take a general look, and then mention certain particulars. Below are listed seven rather random categories within which the fetus and, therefore, the baby may be influenced (for good or bad) by what happens to the mother during pregnancy and labor.

1. Optimum growth of body and organs.
2. Normal development of body and organs.
3. Increased fetal viability.
4. Prevention and therapy of fetal infections.
5. Acquisition of antibodies (useful and harmful) by the fetus.
6. Acquisition of specific nutritional elements.
7. Protection during labor and delivery.

The first of these categories is growth. With respect to this item, animal husbandry would seem to leave no doubt that the weight of the fetus at birth is directly related to the amount and quality of food the mother has eaten during pregnancy. However, this is less clearly true of human mothers and infants. The facts of the matter seem to be that if one studies large groups of pregnancies, infants born to women undernourished during the last trimester of pregnancy will be (on the average) significantly lighter in weight than those born to well-nourished mothers.[12,13] But this is *on the average.* Some well-nourished mothers will have small babies. Some ill-nourished ones will have big babies. I wish I knew why.

As to growth in length, the reports vary. Naturally, less sharp difference will occur than with weight, since length is but one dimension whereas weight is the product of three. Observations with which I am most familiar lead me to believe that fetal growth in length can be influenced by maternal diet,[4,12,13] though the critical period of pregnancy when this influence is most marked has not been determined. In animal studies, striking reduc-

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tion in the weight of certain organs at birth seems to result from limitation of maternal diet.[2] Our own work upon human material in this regard is far from complete. To date, it seems to indicate that, as with animals, the livers of human infants vary considerably in size at birth, and may be lighter if the mother's diet has been inadequate—disproportionately lighter, indeed, than the body as a whole. Since the liver is a storage organ, this is an observation which, if substantiated, will be of importance.

The whole matter of maternal nutrition and prenatal growth is not merely academic. It is a demonstration that fetal growth *can* be influenced and is not merely a matter of chance, germ plasm, and tumor-like parasitism on the part of the fetus. It is also a subject about which we should be informed, as Barcroft[2] says, because of "the prospect of semi-starvation which hangs over much of the world during the present time."

The possibility of preventing fetal maldevelopment is of more immediate appeal, both for the reduction of neonatal and later deaths and for the prevention of a vast amount of unhappiness during unfortunate lives. Warkany's beautiful demonstration[15] that numerous congenital malformations in the offspring can be produced by selective malnutrition of animal mothers in a period corresponding to the first eight weeks of human pregnancy has aroused great curiosity and perhaps some undue hopes regarding the human species. The evidence is not all in yet. At present, it appears likely that a degree of chronic maternal malnutrition sufficiently severe and selective so as to interfere with fetal development must probably be rarely encountered in American mothers. Indeed, such malnutrition is much more likely to prevent conception altogether than to produce living and malformed babies. Still, as Dr. Warkany once remarked, "The most serious congenital malformation is never to be conceived at all."

As is well known, overwhelming evidence indicates that maternal rubella occurring in the first three months of pregnancy may result in rather devastating fetal malformations. In such pregnancies, the mathematical likelihood of the fetus escaping disaster seems to be about 50 per cent, though only forty uninterrupted pregnancies have been studied.[8] As to the effect of other maternal virus infections, data thus far available indicate little possibility that they will result in unfortunate fetal consequences. In fact, I don't think we have real proof yet that chickenpox, measles, or mumps justify interruption of pregnancy.

The potentially preventive aspects of mongolism are being reinvestigated by Ingalls.[7] As a first step he has shown that the great majority of anomalies observed in mongoloid individuals may be explained as a result of deviations in development at about eight weeks after conception. He has gathered evidence that severe gestational hemorrhage (threatened abortion), mechanical disorders of the uterus, and maternal infections may be causative factors in the deviation from normal development. Though most such accidents may not appear easily avoidable, the inference that a defect of germ plasm need not be held responsible allows hope that future studies may point the way toward prevention.

As stillbirth and prematurity are, between them, responsible for about three-fourths of all fetal loss, it is of more than academic interest that two English studies[1,11] upon thousands of women have shown a reduction in both these items following increasing vitamin and mineral intakes during pregnancy.

In our new concern with infection as a cause of malformations, we have tended to forget the actual diseases of the fetus produced by various other antigens. Undoubtedly more infants have been killed by congenitally acquired syphilis than have been deformed by maternal rubella. It is, therefore, of great importance that we now have in prenatal penicillin an agent capable of preventing congenital lues, and, very probably, of curing it in certain already infected fetuses, with the resultant birth of intact infants.[6] Thus, there is every reason to believe that the fetus can not only be protected but presumably be treated by antibiotics and chemotherapeutics administered to the mother. Sulfonamides, penicillin, and streptomycin can favorably affect two patients at once, and, though toxic effects have been reported in the fetus and newborn, they seem no more frequent than at older ages.

Finally, it should be mentioned that various virus infections attacking the mother may be passed to the fetus so late in gestation that neonatal disease may result from prenatal (and preventable) acquisition of these antigens. The infection of the fetus during the act of birth by various organisms such as the gonococcus and streptococcus also deserves mention.

Antibodies, either helpful or harmful, reach the fetus freely through the placenta, and offer a good deal of opportunity for influencing the fetus through the mother. The infant of a woman immune to measles, chicken pox, mumps, or certain other contagious diseases, will have acquired sufficient antibodies to protect him for months after birth, should his exposure occur. We have left this useful phenomenon to nature, but perhaps we should do something about it, as will be mentioned later. We are certainly in a position to improve the present position as regards diphtheria. Now that about 50 per cent of women of childbearing age are not immune to diphtheria, only 50 per cent of newborn infants can be presumed immune. Improvement of this situation is squarely in our hands.

The situation regarding pertussis is particularly interesting since we have so long assumed that the newborn infant will be susceptible, whatever the immunologic status of the mother. Now we know from more than one recent study[5,9] that by raising the maternal antibody titer during pregnancy it is perfectly possible to secure a newborn infant passively and at least relatively immune for some months after birth. This is of much more than academic importance in view of the fact that even if we start actively immunizing infants soon after birth, the best to be hoped is achievement of solid immunity by four or five months.

Though this is not a discussion of the Rh factor, it seems worth pointing out here that at least one unfavorable maternal antibody, that against the Rh factor, offers a challenge to prenatal pediatrics. Some progress has been made by the induction of labor before term as a means of interrupting the acquisition of this undesirable antibody.

TABLE I. INCIDENCE OF TRAUMATIC AND ASPHYXIAL HEMORRHAGE
1931-1935 compared with 1941-1945 (Boston Lying-in Hospital)*

Subjects		Post-mortem Examinations			
		Number	Per Cent Showing:		
			A. Tentorial Tears	B. Gross Hemorrhage	C. Asphyxial Hemorrhage
Premature stillborn	1931-1935	42	2.4	9.5	7.2
	1941-1945	52	1.9	7.8	13.5
Premature liveborn	1931-1935	63	22.0	35.0	9.5
	1941-1945	89	4.5	20.2	12.4
Term stillborn	1931-1935	54	20.0	24.0	7.4
	1941-1945	84	6.8	10.1	11.4
Term liveborn	1931-1935	60	30.0	30.0	10.0
	1941-1945	103	11.6	22.5	18.4

Mortality (Combined neonatal deaths and stillbirths of viable fetuses):
1931-1935—5.05%
1941-1945—3.65%

*Data kindly furnished by Laboratory of Dr. Arthur Hertig, Pathologist, Boston Lying-in Hospital

Besides the relationship of total maternal nutrition to growth of the fetus, certain specific items associated with nutrition deserve attention. It was clearly shown by Strauss[14] that infants of mothers whose iron stores were low during pregnancy tended to develop relatively severe anemia compared to the offspring of mothers in satisfactory nutritional status as regards iron. Here is an element whose supply during prenatal life is under our control; to neglect it is to risk producing a deficiency which will not be apparent till several months after birth.

I mention vitamin K in this context chiefly because so many of the guests at the recent International Pediatric Congress stated that greatly improved control of birth hemorrhages could be brought about by giving oral vitamin K to mothers daily throughout the last month of pregnancy. Careful trial of this might have interesting results. Other vitamins display a relative degree of maternal-fetal correlation, but in most American dietaries they are presumably satisfactorily covered to prevent fetal and neonatal risks.

The final category with which this discussion opened was that of mechanical and physiological protection of the fetus during labor and delivery. Here I should like to make but one point. As

mechanical obstetrics is becoming so perfected that all but an irreducible minimum of traumatic hemorrhages are now avoided, we face in anoxia an increasing problem to be investigated by studies of *physiological* obstetrics. This appears in the decreased incidence of trauma and the concomitant increase in anoxic damage shown by autopsy material at the Boston Lying-in Hospital (Table I).

Having taken a brief view of possibilities in prenatal pediatrics, how can we apply them? Provision of proper maternal nutrition requires only perseverance on the doctor's part and intelligent co-operation on the patient's. The often published dietary recommendations of the Food and Nutrition Board are, to say the least, ample, and are covered in convenient form by easily available diet lists.[3] Adherence to them will assure the fetus an optimal growth of body and organs and a sufficient storage of vitamins, provided, of course, no maternal condition (such as pernicious vomiting or intestinal disease) is interfering with absorption. I wish I could promise that eating such a good diet would guarantee the prevention of even a moderate number of congenital malformations. Present evidence does not quite seem to allow this claim—at least, not yet.

Attention to maternal infection and immunity would be ideally successful (for fetus and mother) if it produced the following state of affairs in child-bearing women: (1) immunity to the common childhood diseases, especially rubella, or at least, strict avoidance of exposure to such infections during pregnancy; (2) active immunity to diphtheria; (3) a high degree of active immunity to pertussis during the latter part of pregnancy; (4) discovery of lues (if present) early in pregnancy, with prompt prenatal treatment by penicillin, and (5) avoidance or adequate therapy of other infections, particularly at or immediately before birth.

Some of these desiderata need no further detailed discussion. It seems to me the best way to deal with the first item would be the prescribed exposure of female children to rubella whenever possible, and even to chicken pox, measles, and mumps as well. Certainly the obstetrician should warn susceptible women who have recently become pregnant against known exposure during that period. If we pediatricians do our full part, all women should arrive at child-bearing age either Schick-negative or with sufficient diphtheria immunity so that a simple Schick test during pregnancy should be a sufficient booster dose to arouse immunity for mother and newborn infant. Pertussis poses a large problem. I should hate to be responsible for insisting that every woman receive three inoculations of whooping-cough vaccine during pregnancy. A more logical hope would be that, as with diphtheria, immunizations carried out in infancy might be re-activated by properly spaced booster doses of vaccine, one of which should be given during each pregnancy.

The rest is a matter for painstaking prenatal care and management at delivery by the obstetrician.

With all of these conditions fulfilled, no one can at the moment promise the medical or lay public a future free from fetal losses or from the birth of a certain number of congenitally afflicted infants. On the other hand, such undesirable results of pregnancy can clearly be reduced in number. The potential magnitude of this reduction would appear to be greater than once was thought.

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MSMS

PROFITS GOING DOWN

A Federal Reserve Board survey of 629 industrial corporations shows that profit dropped to $860 million in the third quarter of 1947. This is $10 million under the first and second quarter totals but still is $7 million above the previous peak of $853 million reached in the last quarter of 1946.

General Practice

The general practitioner is the foundation stone of American Medicine. From him have evolved the various specialty groups which now occupy so prominent a part in the over-all picture of the practice of medicine.

There has been considerable evidence in recent months that the general practitioner is again coming into his own in Michigan. The creation of a Section on General Practice by the Michigan State Medical Society and by the American Medical Association; the organization of the Academy of General Practice; the postgraduate training courses in general practice being given by the University of Michigan Medical School and others, with the financial aid of the W. K. Kellogg Foundation; and the help offered by the Michigan Foundation for Medical and Health Education to undergraduate medical students who are preparing for practice in rural communities, all point in this direction.

It is conceivable that in a comparatively short time the general practice group may have much more voice in the management of affairs medical than it has had for the past several years. This spreading of authority over a larger group should be a healthy sign, and should augur well for the future of the practice of medicine in Michigan. It is axiomatic, however, that added authority always carries with it added responsibility.

What are these responsibilities to which a completely organized general practice group through force of numbers will naturally fall heir? First, it must supervise its own members to the end that they individually render the type of medical service to which the public is entitled, and that they undertake only such technical procedures as they are thoroughly qualified to do. Second, it will be necessary for them to assume a more active rôle in medical organization. In this, they have fine precedent to follow, as some of our most able men in organized medicine have come from the general practice ranks. However, the members of this group, as a whole, are somewhat lackadaisical in this regard. Let them prepare now for the responsibilities that are almost certain to be theirs.

The general practitioner is one who knows much about many things, as compared with the specialist who supposedly knows more about a few things. Each is supreme in his own field, and each should look upon the other not as a competitor, but as an ally.

A more active participation on the part of the general practitioner, coupled with a more tolerant and understanding attitude on the part of the specialist should help to solve our problems in the distribution of medical care.

P. L. Ludwig

President, Michigan State Medical Society

President's



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Editorial

AS THE BELL TOLLS

TO MANY Americans, April is known as Cancer Control Month. While every month is a cancer month for the physician, this is a good time to recall the fact that we do have non-medical allies in the fight against cancer. Their importance and potential power are demonstrated in several ways, not least of which is financial support as shown by such things as the increase in contributions to the American Cancer Society annual fund-raising drive. In 1947, in Michigan alone, this amounted to over $400,000, sixty per cent of which remained in Michigan for local use. Still other private donations and bequests for cancer provided an additional $1,000,000. While not all of the expendable portion of these private funds remained in Michigan, the ultimate good derived from their use will benefit people everywhere. Furthermore, in 1947, Congress appropriated a total of $14,000,000 for cancer research and education. Of this amount approximately $121,765 was allocated to Michigan; $84,015 for distribution through our State Health Department, $24,750 to Wayne University and $13,000 to the University of Michigan. Money will not cure cancer, but it is a very necessary and useful agent in the development of research and cancer control.

Significant, too, is the growing evidence of lay interest. While public concern over cancer is by no means universal, it is gaining momentum and may someday become a powerful factor in bringing control of some cancers within the bounds of practical achievement. Lay interest is no longer limited to the Field Army of the American Cancer Society. In Michigan local concern has been demonstrated by other organizations such as the State Farm Bureau, the Business and Professional Women's Clubs, Junior League Clubs, Rotary Clubs, et cetera. This interest is growing and, like the availability of money for cancer work, is likely to reach sizeable proportions. These things imply progress. They also call for active participation and leadership on the part of physicians, since this is a fight in which the doctor plays a lead role.

If dollars are to be wisely spent and without unnecessary duplication; if lay interest, so essential for prevention, control, and early diagnosis is to be encouraged; if these powerful forces are to be used for greatest good—then we, who have elected to become physicians and thereby assume responsibility for the health of our fellow men must play our part well.

Are you doing your part?

NORMAN L. MILLER

REBATES

GOVERNMENT ATTORNEYS filed a petition in Chicago Federal Court, reported February 13, 1948, asking that 2,750 of the nation's ophthalmologists be named as defendants in pending suits that charge they accepted rebates from optical firms. The original antitrust suits were started in June, 1946, against several large optical firms and fifty-two ophthalmologists.

It was claimed that the rebates resulted in a 100 per cent increase in the price of eye glasses. Willis L. Hotchkiss, attorney for the antitrust division, also asked that the optical firms be ordered to turn over the names of all eye doctors on their records, estimating that 1,500 additional names would be obtained. Thirty-nine Michigan doctors are on the first list, and these names were published on the front page of the *Detroit Free Press,* February 13, 1948. Chicago papers announced that the internal revenue officers are probing the income reports of all 2,750 physicians whose names appeared on the list.

Part of Inspired Smear Campaign Against Medical Profession

One of the Detroit doctors interested in this newest effort to smear the medical profession called his Congressman, in Washington, asking about the news just released, and was told that it was a part of the campaign being carried on, stimulated from Washington, in a continuing effort to place the medical profession behind the eight-ball and to so condition them that final socializing would not be too difficult.

We have repeatedly invited attention to articles of a nature unfavorable to the medical profession. In December, 1947, we mentioned *Harper's, Look,* and *Parade.* The January *Reader's Digest* carried an article by Albert Q. Maisel, whom we have met before, about "Better Vision . . . With a Kickback," saying that over a year ago the government had published the names of fifty-two physicians who had accepted over half a million dollars in rebates, but not a single one of them had been disciplined by their medical societies. Medical journals have joined in this broad charge of accepting rebates, as though it involved the whole profession, asking for discipline.

INNOCENT—UNTIL PROVEN GUILTY

CHARGES such as the one just made, naming thirty-nine Michigan doctors, are no just cause for the medical societies to discipline those doctors. Charges have been made against the whole medical profession, and specifically against these doctors, but no misdemeanor has been proven, and our fundamental law presumes a man innocent until proven guilty. That is not the way the federal bureaucrats and their publicity writers work, however. To their minds, simply to charge a wrong places the accused in the position of having been convicted a criminal, else why the demand for discipline before any justification for action has been made.

Unfortunately, our press aids the bureaucrats by condemning and even convicting citizens in the public news. They do not seem to realize that by running blaring front-page copy and flamboyant cartoons, they are falling for the wiles of a clever propaganda machine which aims not alone to engorge medical practice, but eventually to shackle free speech. Look behind the present general condemnation of the medical profession and you will find a grand scheme to socialize medicine; once that segment of the public is under control, the balance of the socializing program will be accomplished—in entirety—in twenty-five years.

Look at Great Britain which, because of socialism, is no longer GREAT.

"IN OUR OPINION"

THE EDITOR OF the *Detroit Free Press,* in his paper of February 14, 1948, has some things to say about rebates. He says:

"We suppose practically everybody who ever bought a pair of glasses thought he got soaked. That is one of the race's peculiarities, and doubtless oculists learn to bear up under it.

"Now, however, it turns out that in some instances Uncle Sam thinks something is doubtful about the lens and frame price tags. That makes it different.

"Before anyone goes too far with villification of the eye doctor, however, he ought to put on his strongest spectacles and study the charges. By our reading it all sounds rather technical.

"What has been discovered is a system of rebates, according to the Government. 'Rebate' is a polite term for fee splitting. It is our cynical suspicion, however, that fee splitting is a practically universal practice. We don't mean just among doctors, but wherever anyone at all charges a fee and somebody else can more or less legitimately cut himself in on it.

"It's a system which costs the ultimate consumer more than what he gets is worth, quite often. But on the other hand it isn't altogether fair to be hard on some particular group that gets caught splitting fees.

"Also, we are a little sour on latter day antitrust suits in general. They tend to start out with a great rash of headlines and then submerge deep into the docket. Long after, a little item turns up saying that some court has ruled certain arrangements must be dissolved, or perhaps need not be dissolved.

"In either event, the citizen notices very little change in the pressure on his purse."

INCOME TAX COLLECTING

HAVE WE been deceived? We have always understood that income tax reports were inviolate—that even the criminal could make reports of his dishonest gains, and pay income taxes without the fear that he would thus lay himself open to prosecution.

Some examples were given of men who could not be convicted, except of evasion of income tax payments. But now comes the announcement that internal revenue collectors are probing the income of the 2,750 doctors *under charges.* If these records are being used to convict of false reports that is a charge between the doctor and his conscience, or his evading of taxes, and should not be used to blast the whole profession. But if those records are being used to convict of rebating that is an intolerable invasion of our rights, and a perversion of the internal revenue laws.

WHAT IS RIGHT?

THIS MATTER of rebates sometimes classed with fee splitting (it may be a tarring with similar brushes), refers not alone to optical house rebates, but to drug and prescription stores, orthopedic suppliers, et cetera, and is getting much unsympathetic and misunderstood publicity. It is so old that doctors were disturbed by it when we were in school.

We know doctors who made their examinations, wrote prescriptions, sent the patient to an optical house and never saw patient or glasses again. But they received the rebate at the end of the month. Other ophthalmologists established fitting departments in their offices, bought at wholesale, and made a complete charge for a complete service to their patients.

In smaller cities where optical companies were not convenient, we had to render a complete service including frame fitting and adjusting, and made our own financial arrangements, with no optical company in between. Now optical companies are more widely distributed, and some doctors are too busy to bother with fittings and prefer to send their patients to the optician for fittings and delivery of glasses. *Thereby they release to someone else the duty and privilege of making the patient completely satisfied.* The doctor could well expect the optician who does part of his job to charge retail prices. If he accepts a rebate for this service, which he did not render, he is likely to give the whole medical profession bad publicity. He has.

THE ANIMUS

THE BETTER BUSINESS BUREAUS of Los Angeles and of other cities have teamed up with the medical detractors from the government bureaus to smear the doctors in an effort to bring down the price of glasses to the public. In Detroit they went around to stores and purchased unmounted frames, paying from $2.75 to $12.50 for the same thing, then demanded from the doctors a reduction in price. They do not recognize that there is a professional service in a medical examination and fitting of glasses. They insisted it is purely commercial and there should be a competitive price. They insist that the doctors who prescribe only from 15 to 25 to 30 per cent of all glasses can bring the price down. No attempt has been made carefully, to bring the optical business, or the optometrists under suspicion or indictment—a good reason to suspect the animus: A SMEAR CAMPAIGN.

THE ANSWER

IN OUR ESTIMATION, the cutting out of rebates is not so important as the cutting down of the too large profit which the optical firms must be making on glasses. But that is not all. We believe the eye doctor should do the complete job of examination and fitting, and in one over-all charge, not only to save money for his patient, but to have the satisfaction and pleasure of a satisfied patient. We believe the prescribing of glasses is a profes-

sional service, involving much more than the mechanical operation, and if done in that spirit will be recognized and appreciated by the patient. We have discussed this with the Better Business Bureau representatives, and while they couldn't see a professional service, they admitted that there could be no criticism of the program, and no prosecution or criticism of accepting rebates.

We have checked many times with patients who had secured their glasses commercially and almost invariably the total cost has been more than our own total costs would have been. We believe the medical profession has in fact held the prices down.

HOSPITAL FINANCES

BLUE CROSS, the organization for hospital service is having difficulties with increased costs, wages, foods, supplies, everything that goes into caring for the hospital patient. That is a hospital problem and is increasing. Hospitals' source of income is the amount paid by the patients, income from endowments if any, and donations. Expenses have grown so that hospitals have used up their reserves, and must now in most instances depend entirely upon their earnings. And for most of the hospitals, large or small, those earnings are not sufficient.

Income for hospitals comes from ward beds (a low rate—not enough to carry the expense); from semi-private rooms (two or three beds), whose charge is set up to just about break even; and from the private rooms which carry a loading to cover the deficits from other sources. The private beds are not of a sufficiently large proportion, in general, to meet the extra load. Blue Cross enters the two lower categories, with ward and semi-private plans. Some patients take accommodations carrying extra charges, but those do not contribute to the extra load, because of the methods of payment on the basis of costs or charges, whichever is lower. That provision uses the extra payment to reduce the cost figure instead of to reduce the deficit due to costs of operation. The Blue Cross payment method may need some revision, but it is essentially fair. Blue Cross subscribers carry their full share of the load.

An important cause of financial distress of hospitals is the care of indigents, wards of the state, county, or city. Schedules of payment are set up by the state, on an indigency basis, but not designed to cover the costs of hospital operation and maintenance. They are arbitrary amounts which result in the hospital actually losing money for every ward of the public of from two dollars up every day. During the prosperous war years this load was minimal, but it is now increasing, and the state MUST assume its proper responsibility.

The Michigan State Medical Society saw this some years ago, and established a minimum fee schedule for government agencies. The Society took the position that wards of the state are no longer indigent. Their sponsors are the righest corporations on earth and have no rights to force hospitals, or doctors, or nurses to give of their only means of support without chance of protest. That is what the present system amounts to—it is involuntary conversion.

Hospitals, their boards, advisors, friends, and newspapers should enter this cause, and secure a square deal for the humanitarian facilities which must carry on if the health of the public is to be served. We are told that most of the larger hospitals in Michigan cannot remain solvent for more than this present year if no relief is found.

The American people are basically and fundamentally just and fair. They are dependent on hospital and health service when ill, and when those times come they want the hospitals to be functioning. If that is to be the case some justice must be forthcoming. We believe the people do not understand how close hospitals are to financial disaster right now. The only cure is for every interested person to assert himself. Publicity will bring relief. Apathy will bring disaster. The hospitals are asking Blue Cross to step into this breach, but that is neither possible nor just. The most important element of concern is the wards of the state. High costs in general could better be met if all categories of hospital patients paid their costs. Of all those who are spongers on the Hospitals the guardians of state wards are the most flagrant.

But hospitals also must help solve their own troubles. We hate to advocate any increase in rates, but ward patients should pay their way the same as any other. The scheme of low charges in those beds was because most ward cases were actual relief patients, but now there are no such. If patients cannot pay minimal rates, they are put on welfare—wards of the state—and are pay patients.

This is your problem as well as the hospitals'.

Michigan's Department of Health

J. K. Altland, M.D., Commissioner

LOCAL HEALTH UNITS FOR THE NATION

The need for local public health units to provide the six traditional preventive medical services throughout the nation has long been recognized by the members of the medical profession. The optimum size of such units and the areas to be included have been unanswered questions. Now a blueprint for the nation has been developed by the American Public Health Association. Twelve hundred units, each embracing from one to six counties and at least 50,000 persons, will do the job at an estimated cost of $1.00 per capita per year. A unit composed of a health officer, a sanitary engineer, public health nurses and auxiliary personnel will bring measures for control of communicable disease, sanitary supervision and advice, child and maternity welfare efforts, public health laboratory services, vital statistics service and public health education to every community, rural and urban. This report of Dr. Haven Emerson's committee has received the approval of the state health officers and many teachers of public health, and also of sixty-five representative voluntary agencies interested in health.

Members of the medical profession may provide leadership for this movement in various ways. On community health councils physicians may stimulate consideration of the need for a reorganized local public health administration; the establishment of local public health administration; the establishment of local public health units based on the principles of preventive medicine and the geographic boundaries set forth in the Emerson Report, the establishment of positions for local health officers which will offer a salary commensurate with the training required and the responsibility carried and which will be free of political pressure; the choice of local health officers to obtain men well trained in preventive medicine and free of political domination; expansion of schools of public health and other institutions to provide physicians, nurses, engineers, health educators, statisticians, public health laboratory directors and auxiliary technicians in sufficient numbers to meet the rapidly increasing need.

Possibly some local health officers now providing good service on a part-time basis will be slow to see the need for the revolutionary shift to the full-time basis. Local boards of supervisors, town councils and boards of aldermen may hesitate to pool their resources with contiguous units and thus give up some of their local autonomy. Local communities may wonder if it is really necessary to look beyond their present staff of public health workers and bring in specialists trained in public health administrative procedure. The fact that prompt realization of the complete plan may require some years is no reason for failing to begin. The medical profession must assume active leadership locally in this reformation of the local public health administration of the country.

—*The Journal of the American Medical Association,* February 14, 1948.

LOCAL DEPARTMENT IS FOCAL POINT

The front line of public health in Michigan is the local, full-time health department. The local health department brings public health to the community, to the family, to the individual.

Today, in Michigan, seventy-one counties and ten cities representing 92 per cent of the state's population have the services of their own health departments. Only twelve counties are without these services. They are: Gogebic and Marquette, in the Upper Peninsula, and in the Lower Peninsula, Berrien, Clinton, Gratiot, Huron, Ionia, Jackson, Lapeer, Livingston, Montcalm and Tuscola.

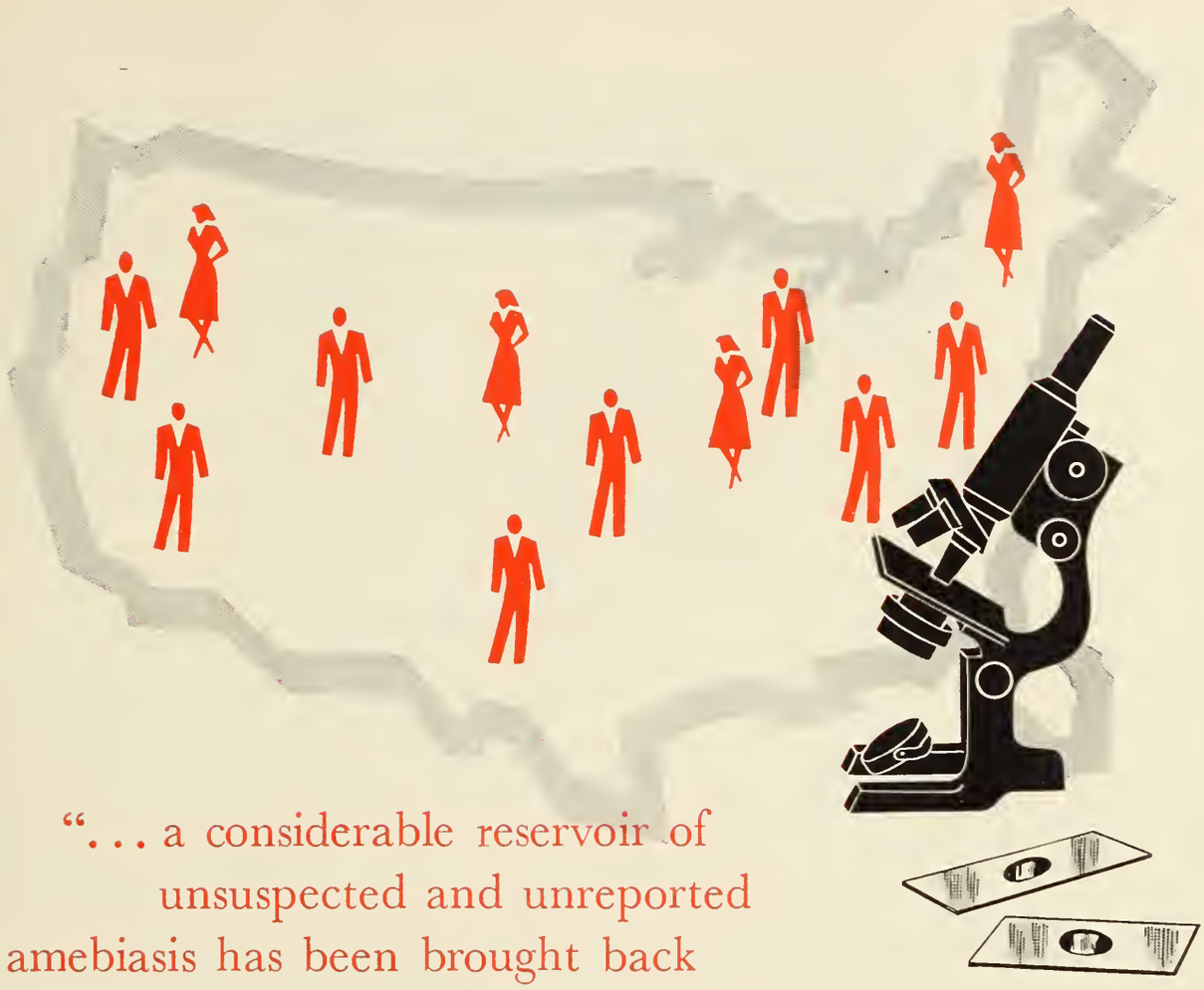
It is our hope that within the not too distant future, these twelve counties will organize health departments so that all of Michigan will be covered. It is gratifying to be able to report at this time that movements are already under way in some of the counties toward the establishment of local health departments. The Michigan Department of Health has received encouraging reports from Livingston, Ionia, Jackson, Lapeer and Gogebic.

The establishment of a local health department is no overnight job, however. A lot of groundwork is necessary. Organization is necessary. Co-ordination is necessary. It means the united effort of many individuals and several groups of individuals. And, most important, it means the support of the local board of supervisors. The board of supervisors does the actual work of establishing the department. The board of supervisors appropriates the funds and through its health committee guides and counsels the health director in administrative matters. And this is as it should be, because the organization and the operation of a local health department fits right into our American way—it is strictly a home rule agency.

The State Health Department is actively interested in administration of the local health department, to be sure, but it is interested as an advisor—as a friend. The State Health Department provides specialized services to the local health department. These services cover a broad field. They include services in maternal and child health, in sanitary engineering, in health education, public health nursing, nutrition, epidemiology, laboratories, to name a few. The result of this availability of specialized services is that the smallest community having its own health department is potentially as well equipped in public health services as our largest cities or counties.

The Federal Government is also interested in the local health department. Through special funds and special programs, it makes possible a more complete health service to the community. But here again, these services are channeled through the local health department. Also, there are private agencies working with the local

(Continued on Page 422)



"... a considerable reservoir of unsuspected and unreported amebiasis has been brought back to the United States...."[1]

Urging clinicians and roentgenologists to be on the alert for signs of this disease, Wilbur and Camp[2] note the frequency with which the radiologist finds unsuspected lesions, ultimately diagnosed as amebiasis.

Diodoquin . . . high-iodine-containing amebacide . . . "is a valuable addition to the therapeutic remedies available for the treatment of this insidious and intractable disease."[3]

Diodoquin may be employed in acute or latent forms of amebiasis. Relatively nontoxic, well tolerated, Diodoquin does not produce unpleasant purgation and may be administered over prolonged periods.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

1. *Editorial: The Problem of Amebiasis, J.A.M.A.* 134:*1095 (July 26) 1947.*
2. *Wilbur, D. L., and Camp, J. D.: Amebic Disease of the Cecum: Clinical and Radiological Aspects, Gastroenterology* 7:*535 (Nov.) 1946.*
3. *Morton, T. C. St. C.: Diodoquin for Chronic Amoebic Dysentery in Service Personnel Invalided from India, Brit. M.J.* 1:*831 (June 16) 1945.*

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Estromone Aqueous Suspension contains crystalline estrogens, chiefly estrone, in a suitable form for prolonged therapeutic action and for ease of administration. Since no vegetable oils are present, allergic manifestations are not encountered as in the case of estrogens in oil solution; pain or induration at the site of injection is rare.

The intramuscular injection of Estromone Aqueous Suspension provides a depot at the site of injection from which the estrogen is gradually absorbed. Such a repository injection may be compared to the implantation of small pellets since gradual absorption of the hormone in the blood stream provides a prolonged effect.

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LOCAL DEPARTMENT IS FOCAL POINT

(Continued from Page 420)

health department. They too provide money for special projects. The W. K. Kellogg Foundation and the Children's Fund of Michigan are notable examples of these agencies.

Public health is truly big business in Michigan. This year $11,567,294 is being spent for public health in our state. . . . By far the biggest share (76% or $8,853,704) is appropriated by the cities and counties for their local health departments. The Federal Government provides 14 per cent (or $81,578,912) of the total and the State Government, 6 per cent (or $747,935). Four per cent, or $386,743, comes from agencies like the Kellogg Foundation and the Children's Fund of Michigan.

—*Michigan Public Health,* February, 1948

EMIC CLOSES

The Federal Emergency Maternity and Infant Care program which has provided maternity and pediatric care to 44,000 wives and 9,000 babies of Michigan servicemen in the four lowest pay grades is nearing its close. The program has been administered by the Department.

The EMIC program will continue to pay for maternity care for eligible servicemen's wives only through this spring. Payment for maternity care will be made only for those cases where the baby is to arrive by April 4, 1948. Babies which are delivered to wives of eligible servicemen by that date may receive protective treatments against diphtheria, whooping cough, and smallpox, as well as medical, hospital and nursing care for illness at government expense until they are one year of age.

Since the program began on May 27, 1943, a total of 53,380 cases have been authorized by the Department which administered the program in the state and a total of $5,043,277.58 has been paid for medical, hospital and nursing care for wives and babies of eligible Michigan servicemen. Of this amount $4,524,574 was spent for maternity care and $518,703.58 was paid for pediatric care. A total of 3,236 physicians participated. Hospitals participating numbered 184, maternity homes, 11, and office delivery services, 2.

There are now 3,479 mothers and babies on the rolls for whom care has not yet been completed. Still others may be added.

Qualifications which have to be met for the EMIC program are: The husband must have been in service on or before June 30, 1947. The wife must have become pregnant before June 30, 1947. The husband must have been in one of the four lowest pay grades or an aviation cadet at some time during the wife's pregnancy and before July 1, 1947.

Any infant under one year is eligible for care if the father of the child was serving in one of the four lowest pay grades during the mother's pregnancy and before July 1, 1947, or if the father was serving in one of the

(Continued on Page 424)

Say you saw it in the Journal of the Michigan State Medical Society



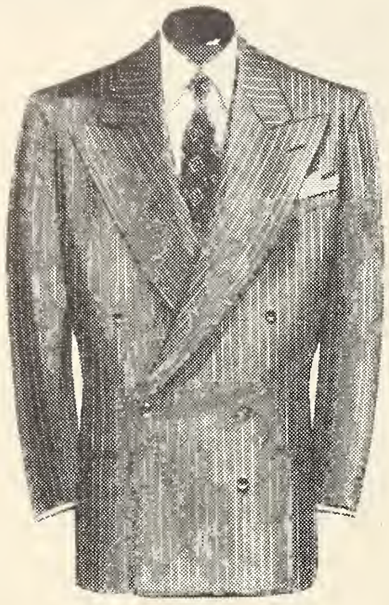
Some things you can argue about . . . but not baby's milk!

There are lots of questions about child raising that are open to discussion.
But there is no room for discussion when it comes to the quality of milk. Milk for growing children must always be dependable . . . always pure and wholesome and perfectly pasteurized. That's why so many mothers insist upon Borden's Quality Controlled milk . . . and why so many physicians recommend Borden's milk to their patients. Borden's is dependable!

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EMIC CLOSES

(Continued from Page 422)

four lowest pay grades during the infant's first year of life and before July 1, 1947.

The last authorizations to be made under the EMIC program will be for care given eligible infants on April 4, 1949.

Under present policies, the wives and infants of servicemen who enlisted since June 30, 1947, are not eligible for the benefits. This emergency program should not be confused with the regular medical and hospital benefits to which all servicemen and their families are entitled if care can be given by army and navy physicians in available government facilities.

INSPIRATION

"When Dr. Leonard A. Scheele becomes U. S. Surgeon General next April, the spirit of Michigan's late Dr. C. C. Young will be carried into the world's highest public health office.

"Dr. Scheele who has been named by President Truman to succeed Dr. Thomas R. Parran as surgeon general still regards Cy Young, founder and director of the Michigan State Health Department Laboratories, as his inspiration.

"It was when Dr. Scheele was attending Wayne University in Detroit that Dr. Young was one of his instructors. Devoting his own life to public health the older man also attempted to interest qualified beginners in the service. Dr. Scheele was one of the youngsters who was impressed."

—W. F. Pyper in *Flint Journal*

Dr. Scheele, forty, one of the youngest surgeon generals of all time, is a graduate of the University of Michigan and of the Wayne University College of Medicine (1934). He has been an officer in the USPHS since 1934. He held a special fellowship in cancer in Memorial Hospital in New York City from 1937 and 1939, and then took charge of the National Health Institute's cancer control program until 1942.

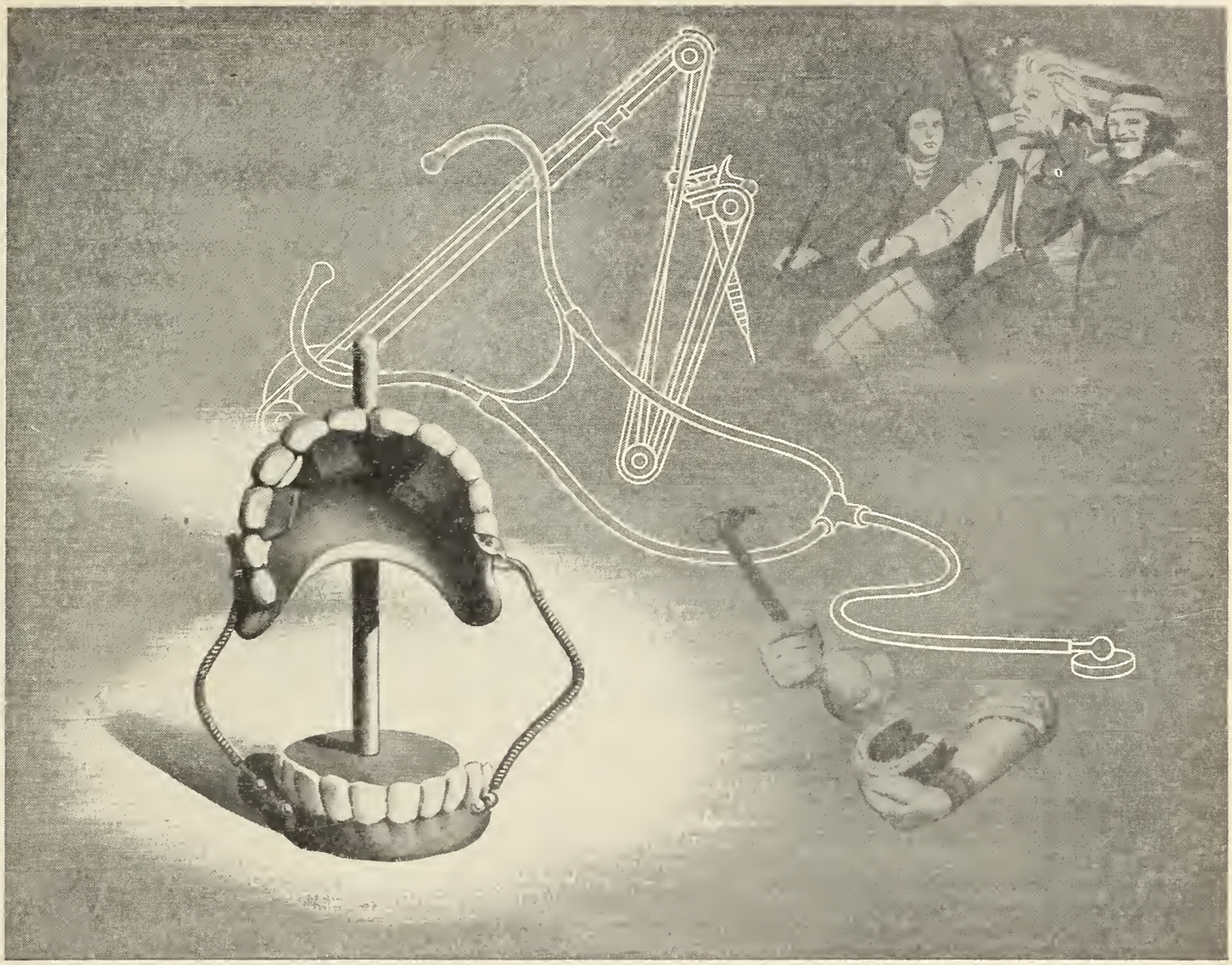
From 1943 until the close of the war he was with General Eisenhower in Europe. Here he earned the Legion of Merit, the American Typhus Medal and the French Government's Order of Public Health for work in controlling typhus in the areas France and Britain gained from Germany.

In the *Flint Journal* article, Pyper points out that interior construction of the health and cancer institute buildings just outside Washington is strongly reminiscent of the state health department laboratories just outside Lansing. Dr. Scheele, he says, explained that the Federal agency followed a pattern set by Dr. Young when he supervised architecture of the Michigan laboratories under the work relief program of the 1930's.

COMMUNICABLE DISEASES DROP

Communicable disease cases reported in Michigan dropped 40,000 last year. The decrease from 140,067 in 1946 to 100,773 in 1947 is largely attributable to the

(Continued on Page 426)



The First Specialized Dentistry

Dentistry was only a "sideline" for goldsmiths, blacksmiths and strolling barbers until the French and American Revolutionary era. France demanded schooling for dentists in 1697; and Pierre Fauchard (1690-1761) soon reported systemic infection caused by teeth, used pivot teeth and crowns and made dentures complete with artificial gums.

Two favorite figures of the American Revolution symbolize the "before" and "after" of the *dental* revolution. Paul Revere was rendering dental services in addition to his smithing and engraving in 1773, while George Washington's dentures (illustrated above) were carved from a hippopotamus tusk by a full-time dental *specialist!*

But doctors still had no specialized *protection*. In 1794, in the first American malpractice case to be appealed, the defendant had no trained malpractice attorney to defend him and no malpractice insurance to pay his judgment.

Doctors Today need not depend, for their protection, upon companies offering malpractice insurance as just another "sideline." *Specialized* malpractice protection—*complete, preventive and confidential*—has been assured by the Medical Protective policy since 1899.

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RIGHT LEFT

Dotted line on cut shows outline of normal shoe. Shoe cut shows abnormal outward swing of Sabel's Club Foot Shoe.

Sabel's Club Foot Shoes are for use after the doctor has over-corrected the position of the club foot. The outward swing of this shoe braced by the long outside counter will tend to keep the position the doctor desires.

Sabel's Surgical Shoes are carried in pattern and leather matching the Club Foot Shoes so that where required, even in split sizes, they can be fitted to the other foot.

The Sabel Line includes, in addition to the Club Foot, the Pre-walker, Brace, Pigeontoe and Surgical Shoes

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COMMUNICABLE DISEASES DROP

(Continued from Page 424)

drop from 42,261 to 9,583 in cases of measles which was epidemic in 1946.

Syphilis and gonorrhea, while they were declining after wartime peak, led all other major communicable diseases in 1947. Whooping cough was in third place, and measles, which led all major communicable diseases in 1946, was in fourth place.

Tuberculosis was in fifth place but its apparent increase was closely related to the wider use of mobile x-ray units in case finding. Nearly half the 6,470 cases reported during the year were found by Department mobile units, alone.

Increase in reported cases of Salmonella infections (animal diseases transmitted to humans) was also related to improved diagnostic facilities provided by the Department and the United States Public Health Service intensified Salmonella study in the state. Better reporting, as well as diagnosis, accounted for an apparent increase in undulant fever, another human ailment of animal origin.

A decrease in malaria was due to the fact that most Michigan servicemen had returned from the Mediterranean and South Pacific theaters where the disease was prevalent.

Polio was not epidemic during 1947 and many of the 646 cases counted for the year were part of the 1946 epidemic which carried over into February.

The cases of major communicable diseases for 1946 and 1947 follow: Syphilis, 18,051—15,276; gonorrhea, 12,527—10,989; whooping cough, 8,116—10,483; measles, 42,261—9,583; tuberculosis, 5,548—6,470; scarlet fever, 5,977—4,819; poliomyelitis, 1,091—646; undulant fever, 135—303; malaria, 1,305—148; meningococcic meningitis, 185—113; Salmonella infections, 83—111; typhoid fever, 85—77; influenzal meningitis, 33—43; and smallpox, 3—1.

RABIES SPREADS IN SPRING

This is the time of year when rabies is spread among animals.

There were 332 cases of rabies among animals in Michigan in 1947. The 2,211 people who had been bitten by them, or in close contact with them, spent approximately $456,575.00—nearly a half million dollars—for anti-rabic treatment.

Rabies was epidemic in the southwest part of the state in 1947. The majority of the 332 cases among animals was in Berrien, Kalamazoo, and Van Buren counties. Dog quarantines of three to six months' duration were established in Berrien, Kalamazoo, Van Buren, St. Joseph, and Washtenaw counties during the year.

Of the forty-four cases of rabies reported up to March 5 this year, the majority were in Cass, St. Joseph, Oakland, and Berrien.

Four measures will help prevent rabies and hydrophobia. All dogs should be vaccinated. Quarantines

(Continued on Page 428)

From birth to the end of the bottle-feeding period



BAKER'S MODIFIED MILK

—well tolerated by both premature and full-term infants



POWDER

LIQUID

Baker's Modified Milk is supplied as powder or liquid. Both forms may be fed interchangeably to meet individual requirements.

YOU will be pleased by the highly satisfactory growth, firm muscle tone and tissue turgor when you prescribe Baker's Modified Milk, because Baker's is a highly nutritious food complete (except for Vitamin C) for infants from birth throughout the bottle-feeding period.

Closely conforming to human milk, Baker's is well tolerated by both premature and full-term infants. No change in formula is required as the baby grows older—just increase the quantity of feeding.

These are qualities making Baker's Modified Milk a fast-growing favorite among doctors. Obstetrical department personnel and mothers are especially pleased when Baker's is prescribed, because Baker's requires no complicated feeding directions. For normal feeding strength, merely dilute liquid Baker's with equal parts of boiled water.

Just leave instructions with the obstetrical supervisor at the hospital. She will be glad to put your bottle-fed babies on Baker's.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 400 units of vitamin D per reconstituted quart.

Complete information and samples gladly sent to physicans on request.

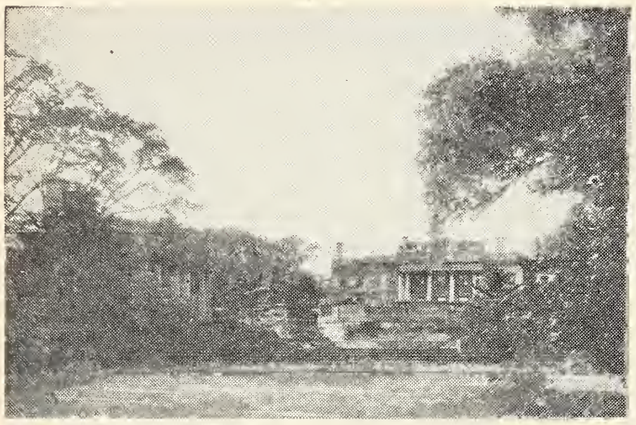
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RABIES SPREADS IN SPRING

(Continued from Page 426)

should be established in infected areas. Stray dogs should be avoided and reported to officers. A person bitten by an animal should see his physician at once.

MEASLES HIT 1,500 MARK

Measles had reached the 1,500 new cases a week mark in the state, by the first of March.

The epidemic which started four months earlier in Kalamazoo city and county had subsided in that area but had spread into the surrounding counties and was flanging into areas adjacent to them. The counties hit hardest by the disease were Berrien, Kent, Cass, Ottawa, Calhoun, Barry, Eaton and Ingham. Across the state, there was increasing incidence of measles in Washtenaw county and the disease was expected to spread from there also.

A total of 1,657 cases of measles were reported to the Michigan Department of Health during the week ending March 5. There were sixty-nine cases of measles during the same week last year, and 3,669 during the week in 1946, an epidemic year.

VD INCREASES AMONG TEEN-AGERS

More than 2,700 teen-age girls and boys in Michigan will contract either syphilis or gonorrhea this year, unless there is definite change from the 1947 venereal disease pattern.

Yearly incidence of venereal disease among Michigan teen-agers has increased 50 per cent since the beginning of the war.

Investigations show that many of the girls and boys infected have little or no knowledge of the seriousness of venereal disease or of the manner in which it is contracted. Much of the information many teen-agers and adults have is only ignorant whispering from behind the barn or from street corners.

The local health departments and the state health department, Lansing 4, have pamphlets on venereal disease facts for each age level, which are available without charge to anyone who has use for them.

PLAN FOR NATION'S YOUTH

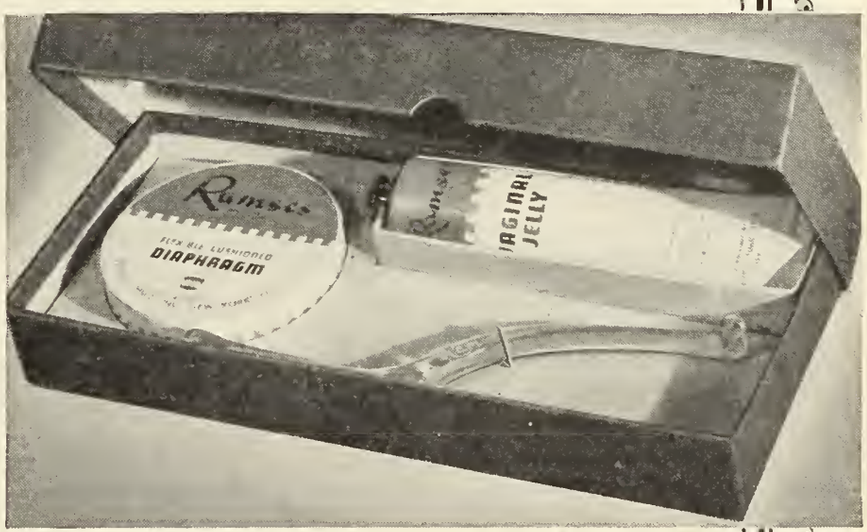
A seven-member committee to represent Michigan at a national conference on state and community planning for children and youth to be held in Washington March 29 to 31, has been named by Governor Sigler.

The conference is preparatory to the 1950 White House Conference on child and youth problems.

Dr. J. K. Altland, State Health Commissioner, and W. J. Maxey, State Social Welfare Director, are co-chairmen of the group. Other members of the committee are: David Addy, Detroit, chairman of the American Legion's National Child Welfare Committee; Mrs. Karla Parker, Grand Rapids, past president of the Michigan Congress of Parents and Teachers; Mrs. Helen Mills, Kal-

(Continued on Page 430)

THE CLINICIAN'S CHOICE



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A report† covering a comprehensive study reveals that the diaphragm-jelly technique is the overwhelming choice of clinicians versed in conception control.

In keeping with this authoritative opinion, we suggest the specification of the "RAMSES"* Prescription Packet No. 501 when you desire to provide the patient with the optimum in protection.

The quality of "RAMSES" Gynecological Products is the finest obtainable. They are available through all recognized pharmacies.

Active Ingredients: Dodecaethyleneglycol Monolaurate 5%; Boric Acid 1%; Alcohol 5%.

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†Human Fertility 10: 25 (Mar.) 1945.

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PLAN FOR NATION'S YOUTH

(Continued from Page 428)

amazoo, past president of the Michigan Division of the American Association of University Women; Karl Zeisler, Monroe, editor of the *Monroe Evening News;* and Floyd Starr, Albion, President of Starr Commonwealth for Boys.

TOWARD BETTER WORLD HEALTH

Dr. F. C. Ke, of the Chinese National Health Administration, Shanghai, a fellow of the world health organization, studied the production and standard tests of penicillin and streptomycin in the Laboratories during January and February.

Departing for his home country, he took with him standard cultures of the antibiotics which he will use in operating a new production laboratory set up just outside Shanghai. Having studied laboratory procedures and tests in the Department, he will stop in New York to visit the large commercial producers of the antibiotics.

Dr. Pyung Hak Lee, director of a biologic products laboratory in Korea who is studying for his Master's Degree at the University of Michigan under a Rockefeller fellowship, is working in the Department Laboratories until September 1.

Ten University of Michigan graduate students in epidemiology will study in the Laboratories each Friday during the semester.

Six University of Michigan graduate students in public health administration are studying the operation and functions of the state health department each Friday of the semester.

FILM CATALOG PREPARED

The 1948 catalog of the Michigan Department of Health Film Loan Library, listing 105 health films and twenty-six film strips, has been published and is available from the Department.

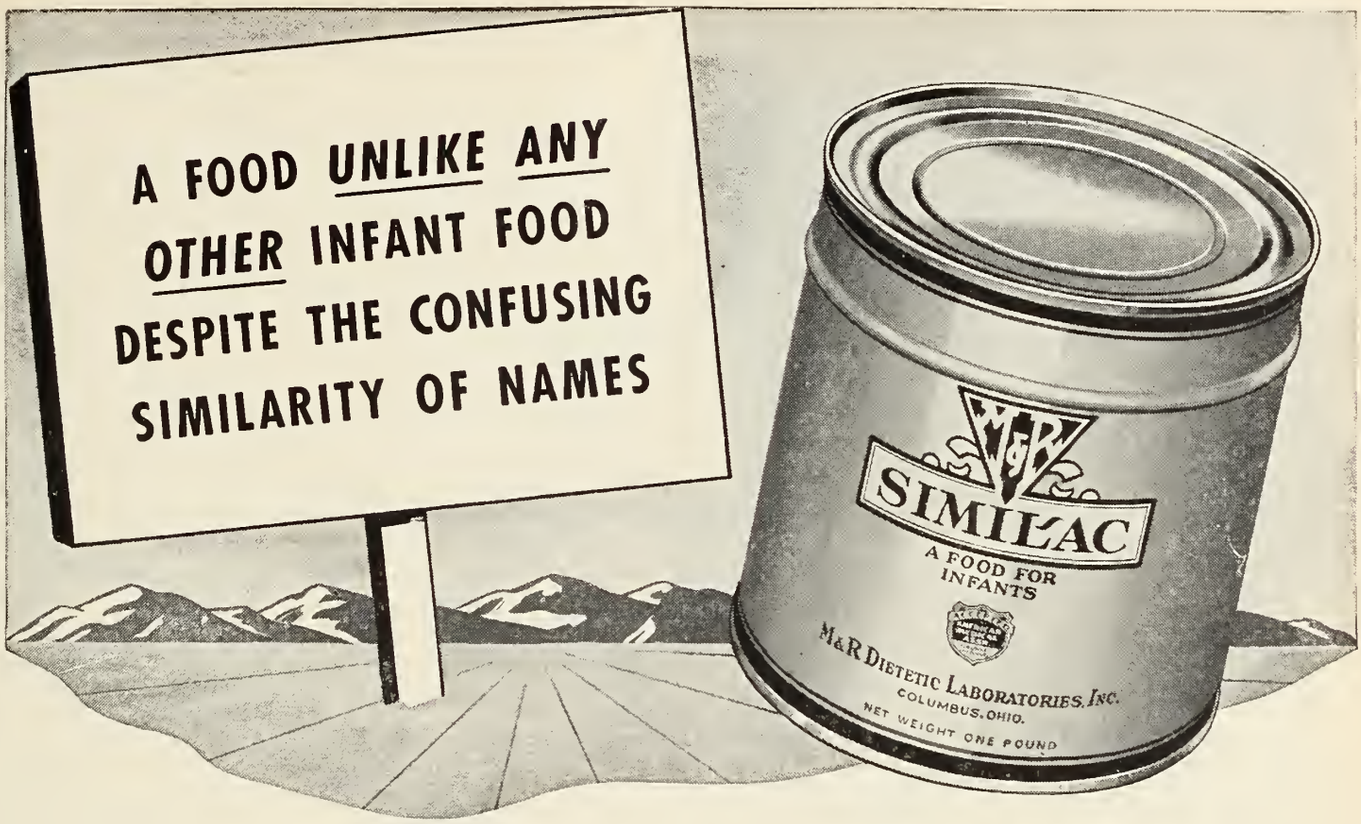
The films are for all age levels of lay and professional persons. Subjects include: baby care, cancer, child health, dental health, diphtheria, dysentery, environmental sanitation, first aid, food sanitation, hearing, industrial health, immunization, infantile paralysis, insects, malarial, history of medicine, milk sanitation, nursing, nutrition, personal health, physical therapy, pneumonia, posture, feet, prenatal care, public health administration, rat control, safety, school health, sewage treatment, sight conservation, swimmers' itch, tuberculosis, venereal diseases, water supply and others.

The films were shown to 5,006 different groups, composed of 278,774 persons, last year.

LOCAL DEPARTMENTS EVALUATE SERVICES

Michigan's fifty-seven local health departments are now evaluating the services they are affording their respective communities on the basis of standards set up by the American Public Health Association and adopted by the Michigan Department of Health.

(Continued on Page 432)



THE FAT of Similac is not all butter fat, but a homogenized combination of fats that is balanced chemically and metabolically to the infant's requirements.

THE CARBOHYDRATE in Similac is lactose.

THE MINERALS in Similac are adjusted to closely approximate the minerals of breast milk.

THE PROTEIN of Similac is rendered soluble to a point approximating the soluble protein in human milk.

THE CURD TENSION of Similac is the same as that of breast milk — consistently zero.

No other substitute resembles breast milk in all of these essential respects.

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A powdered, modified milk product, especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

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Similar to breast milk



Relax Tension
Relieve Pain
Reduce Congestion

—in chest conditions, neuralgia, sinusitis, myalgia, bronchitis, sprains, backache—

with the "heat therapy" of the Burdick Zoalite.

All models are equipped with the famous nonmetallic element which emits a high percentage of infra-red irradiation with a minimum of visible rays.

The DUAL ZOALITE, above, meets exacting clinical requirements for irradiation of large or small areas.

For information on Burdick Zoalites, drop us a line, the Burdick Corporation, Milton, Wisconsin, or contact your local Burdick dealer.

Council Accepted. Burdick

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4444 Woodward Avenue, Detroit 1, Michigan

LOCAL DEPARTMENTS EVALUATE SERVICES

(Continued from Page 430)

When the summing up is complete, the local health department's evaluation report is submitted to the Michigan Department of Health where it is graded by the field staffs of the Department and the American Public Health Association.

After the evaluation schedules have been graded, consultants from the state health department are available for follow-up visits to the local departments to assist with plans for improving the current and long range programs of the local department. These consultants are also available at any other time of year, upon request, to aid with matters of health education, nursing, nutrition, hospitals, sanitation, maternal and child health problems, school health programs, industrial health, pest control, community participation, public relations, record keeping and administration.

These services are afforded to local health departments to plan with them in developing their services to their communities and in improving the health status of Michigan.

The fifty-seven local departments, which include thirty-one county units, fifteen district units, and ten city units, are now serving 92 per cent of the state's population. The department hopes that local health units may soon be established in the twelve counties of the state which now have no such services.

IMMUNIZATION FOLDER AVAILABLE

The Department has prepared an illustrated immunization folder, "Are Your Children Protected?" giving the proposed schedule for use of single antigens as protection against diphtheria, whooping cough, smallpox, and tetanus. The folder is written for the lay public and is available in quantities from the local or state health departments.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*February, 1948*	*February, 1947*
Diphtheria	14	21
*Gonorrhea	785	939
Lobar pneumonia	85	90
Measles	5538	493
Meningococcic meningitis	9	13
Pertussis	452	880
Poliomyelitis	3	9
Scarlet fever	675	620
*Syphilis	1140	1428
Tuberculosis	437	495
Typhoid fever	4	3
Undulant fever	8	18
Small pox	0	0

*Tentative figures.



GOOD INSURANCE WHEN *Under-Nutrition* THREATENS

When increased nutrient needs, finicky appetite, or food aversions threaten the nutritional state by limiting food intake, the delicious food drink made by mixing Ovaltine with milk is employed to advantage.

This nutritional supplement proves good insurance against an inadequate nutrient intake, since three glassfuls daily brings even an ordinary diet to optimal levels. It supplies generous amounts of all the nutrients considered essential: biologically adequate protein, B complex and other vitamins including ascorbic acid, readily utilized carbohydrate, easily emulsified fat, and important minerals. Adults and children both enjoy the delicious taste of Ovaltine. Hence it is readily taken by all patients in the recommended quantity.

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Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

Woman's Auxiliary

● Macomb County organized an Auxiliary and elected officers January 20, 1948, with Mrs. Austin Heine, 169 North Avenue, Mt. Clemens, Michigan, as president. This is the twenty-fifth Auxiliary and a warm welcome is extended to them and to the twelfth new member-at-large, Mrs. S. R. Russell, St. Johns, Michigan.

* * *

● The campaign for selling Easter Seals for Crippled Children started February 28, and several counties are helping with the sale. Bay County Auxiliary sponsors and stages the entire Easter Seal Sale in that county and the past year raised $6,000, of which 50 per cent remained in Bay City to aid in equipping a physical medicine room in the General Hospital.

* * *

● Saginaw County Auxiliary sponsored a Public Relations meeting January 20 when J. S. DeTar, M.D., Milan, MSMS Speaker, and Hugh W. Brenneman, Lansing, Public Relations Counsel of the State Society, discussed voluntary medical insurance versus government control of medicine. Saginaw also gave a Christmas party for all members' children during the holidays, when 107 were entertained.

● Genesse County Auxiliary entertained the wives of dentists and druggists at a tea in January. George A. Hays, M.D., Flint Health Officer, was the speaker.

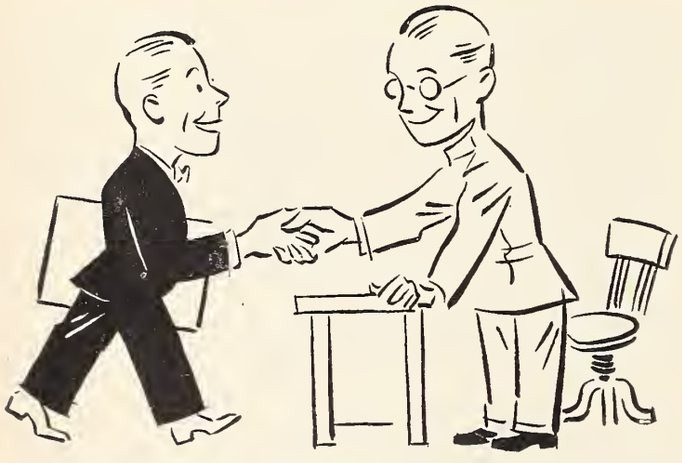
* * *

● Jackson County Auxiliary had a meeting in January devoted to the subject of crippled children. G. Arthur Norcross was the speaker, and Gilbert Zook showed movies taken at the crippled children's camp at Wolf Lake.

* * *

● Midland County Auxiliary announces the presentation of gift subscriptions of *Hygeia* to twenty Midland County schools. Selection of schools was made following consultation with county school authorities to determine which schools could make best use of the magazine.

Life expectancy of the average American in 1838-1854 was 40.9 years; in 1900-1902, 49.2 years; in 1947, 65.8 years. It is fast approaching the biblical three score and ten limit.



WELCOME!

Every Day

MONDAY thru SATURDAY

Being available is mighty important! We try to match the physician's working week so that our technical services can be available to him and his patients every day. Our efficient, accurate service for filling optical prescriptions is maintained Monday through Saturday—daily, 9 to 5 and Mondays to 7 P.M.

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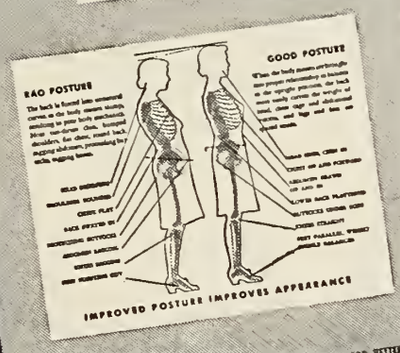
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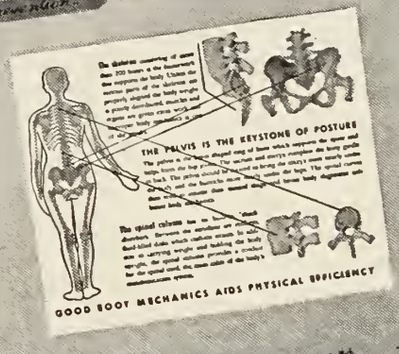
Office Hours: Daily, 9 to 5; Mondays to 7 P.M.

10th annual CAMP NATIONAL POSTURE WEEK MAY 3-8

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AVAILABLE: Two interestingly illustrated 16 page booklets on posture prepared especially for distribution by physicians to their patients. Their titles: "The Human Back—Its relationship to Posture and Health" and "Blue Prints for Body Balance." Ask for the quantity you need on your professional letterhead. THE SAMUEL HIGBY CAMP INSTITUTE FOR BETTER POSTURE, Empire State Bldg., New York 1, N. Y. Founded by S. H. Camp & Company, Jackson, Mich.

In its tenth year, Posture Week will again highlight our year-round program of focusing attention on the significance of good posture as an important element in good health and physical fitness.

Through practical cooperation and voluminous correspondence physicians, educators and lay groups in the field of public health have expressed their appreciation for this work.

Naturally, we hope to again merit the continued cooperation and approval of the medical profession.

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World's Largest Manufacturers of Scientific Supports
Offices in New York, Chicago, Windsor, Ont., London, Eng.

What's What

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of February 18, 1948

- Monthly financial reports and bills payable were presented, studied and approved.

- $30,000, allocated in 1947 from Public Education Account to Reserves, were definitely segregated for PE Reserves.

- Thanks voted to E. F. Sladek, M.D., Traverse City, on his successful conduct of the National Conference on Medical Service in Chicago, February 8, with Michigan as host state; congratulations extended to Dr. Sladek on his election as President of the Conference.

- Report on progress of Michigan's Immunization Month presented.

- Reports accepted from Public Relations Committee, Committee on Basic Science Law, Industrial Health Committee, State Interprofessional Committee; report received from Committee on Blood Program, pending advice from Michigan's County Medical Societies on the subject matter.

- Two Lansing physicians appointed to special committee seeking more adequate accommodations for MSMS Executive Offices.

- "MSMS Membership Month" (April, 1948) inaugurated.

- E. C. Baumgarten, M.D., Detroit, appointed one of MSMS representatives to Board of Michigan Hospital Service.

- Statement re Michigan Hospital Construction and Survey Act approved, as follows:

  "The Executive Committee of The Council, Michigan State Medical Society, believes that the present Michigan Hospital Construction and Survey Act (Act No. 299 of the Public Acts of 1947) is sufficient to qualify Michigan hospitals for benefits under the Federal Hospital Survey and Construction Act (U. S. Hill-Burton Act). At most the Michigan law needs but minor changes. In no event does it require amendments having the effect of compelling the licensing of hospitals.

  "If a hospital licensing law is to be proposed for Michigan, it should be submitted in a separate bill and considered on its own merits."

- Statements of Michigan Pathological Society on (a) making cancer a reportable disease; and, (b) on Rh testing by State Health Department, approved.

- Monthly reports of President P. L. Ledwidge, M.D., President-Elect E. F. Sladek, M.D., Secretary L. Fernald Foster, M.D., General Counsel J. Joseph Herbert, and Public Relations Counsel H. W. Brenneman accepted.

Frederick Margolis, M.D., of Kalamazoo, addressed the Van Buren County Medical Society at its February meeting in Lawrence on the subject of "Diagnosis of Diseases of Children and Their Medical Care."

* * *

J. Joseph Herbert, J.D., Manistique, General Counsel of the Michigan State Medical Society, was elected to honorary membership in the Delta-Schoolcraft Medical Society on February 25.

* * *

The proposed federal budget next year is $39.8 billion. If passed, Michigan's share would total $1.7 billion. This is approximately 4½ times the $371 million Michigan spent for all purposes in 1947.

* * *

"*Socialized Medicine* is another Utopian scheme to convince the American people they can get something for nothing."— J. C. PENNEY, Chairman of J. C. Penney Company.

* * *

Warren W. Babcock, M.D., Detroit, was elected a director of the Association of American Physicians and Surgeons at its recent annual meeting in Colorado Springs, Colorado.

* * *

President Truman has requested Federal Security Administrator Oscar R. Ewing to make a "comprehensive study" of the possibilities of raising health levels and for suggestions for "feasible goals" which might be realized during the next ten years.

* * *

One out of three persons in the United States now has some form of voluntary insurance against the costs of illness, the National Industrial Conference Board estimates. The latest enrollment figures of Michigan Medical Service are 961,000.

* * *

Wm. J. Burns, Lansing, MSMS Executive Secretary, addressed the American Academy of General Practice of Wayne County at its annual meeting in the Book-Cadillac Hotel, Detroit, on March 11. His subject was "Futures in General Practice."

* * *

J. S. DeTar, M.D., Milan, Speaker of the MSMS House of Delegates, spoke to the Woman's Auxiliary to the Kent County Medical Society on February 11 in the Pantlind Hotel, Grand Rapids. His subject was "Better Health in Michigan."

* * *

The St. Clair County Medical Society designated its dinner meeting of March 9 as "DeGurse Night," in honor of their member, T. E. DeGurse, M.D., Marine City, chosen as Michigan's Foremost Family Physician by the Michigan State Medical Society.

(Continued on Page 438)



Let's Weigh the Facts About BABY QUAKER

A glance at the accompanying analysis will show that the nutritional benefits of BABY QUAKER Instant STRAINED OATMEAL deserve serious consideration. Here are the body-building, whole-grain benefits of Mother's Oats (Mother's Oats and Quaker Oats are the same)—fortified with vitamins and minerals, and especially processed for the delicate digestive systems of little babies. Its fine texture and precooking for instant preparation make it a welcome aid in baby feedings. The Quaker Oats Company invites inquiries about Baby Quaker Instant Strained Oatmeal.

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Typical Analysis of Baby Quaker Oatmeal

Protein	15.1%
Fat	7.2%
Carbohydrate	64.1%
Fiber	1.7%
Total Minerals (Ash)	4.6%
	Per Ounce
Calories	108
Calcium	230 mg.
Phosphorus	277 mg.
Iron	6.6 mg.
Thiamine	0.44 mg.
Riboflavin	0.063 mg.
Niacin	0.406 mg.

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Do you long to be isolated on the "bigwater"? If so I have the most attractive spot in Traverse Peninsula on Lake Michigan. High and dry with white sand beach. Heavily timbered with pine and hardwoods. Throw the yacht anchor in the front yard or move it a few hundred feet to natural Bowers harbor. This harbor is safe and long enough to land your Seebee on. Yours for the asking—Small plat and illustrated brochure. Write today.



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Do you want the safe cool crystal clear water of wonderful Torch Lake, third most beautiful lake in the world? I have large sandy beach lots with ample cedar and spruce shade after you cut your cottage logs on your own lot. No swamp even near you. A natural for canoe and small boats. Excellent for sailing and a yacht club near you. Good fishing with hardly a mosquito, which you can't do on most Michigan lakes. Highly Restricted from $1500.00 up. Terms, if you wish.

Write or Phone—Howard D. Pavey, 537 E. Baker Street, Flint, Mich.

(Continued from Page 436)

The American Society for the Study of Sterility is holding its fourth national session at the Congress Hotel, Chicago, June 21 and 22, 1940. For additional information, write John O. Haman, M.D., 490 Post St., San Francisco 2, California.

* * *

Renew your federal and state narcotic licenses on or before July 1, 1948. Send check to the Federal Bureau of Narcotics, Federal Building, Detroit; the state check is to be sent to the Michigan State Board of Pharmacy, 502 Olds Tower, Lansing 8.

* * *

The medical profession of Britain is against the labor government program of socialized medicine. The poll of the BMA members showed 25,340 against the law in its present form and 1,408 were in favor. The law becomes effective July 5, 1948.

* * *

R. H. Lyons, M.D., S. W. Hoobler, M.D., R. B. Neligh, M.D., G. K. Moe, M.D., and M. M. Peet, M.D., Ann Arbor, are authors of an original article, "Tetraethylammonium Chloride," which appeared in *JAMA* of February 28.

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, was guest speaker at the West Virginia Medical Society's Secretaries Conference and at a meeting of its Council in Charleston on Sunday, March 14. His subject was "Making Friends for Medicine."

GT-L-B County Medical Society.—Todd Mallory, M.D., of the University of Michigan, addressed the Grand Traverse-Lelanaw-Benzie County Medical Society, March 8, on "Laboratory Procedures of Use to the Clinician." Dinner was at the Park Place Hotel, Traverse City, and the attendance exceeded twenty-five members.

* * *

The Michigan Blue Cross plan reports that 26,978 babies were "paid for" in advance, in 1947. This brought the total of Blue Cross babies (whose parents are subscribers in Michigan Hospital Service-Michigan Medical Service) to 134,306 since 1939, when Blue Cross began in Michigan.

* * *

"Facts and Figures About Infantile Paralysis," a publication of the National Foundation for Infantile Paralysis, is now available to doctors of medicine. The booklet contains valuable information and statistics on the disease. For free copies, write the National Foundation, 120 Broadway, New York 5, N. Y.

* * *

Orchid to MSMS.—"For several years I have had different contacts with some of your leaders in the Michigan State Medical Society, and all the medical world knows how much the AMA and all the state societies owe to the virility and the leadership of the men from Michigan."—C. C. Burlingame, M.D., Hartford, Connecticut (guest speaker at 1948 MSMS Annual Session).

Say you saw it in the Journal of the Michigan State Medical Society

Paul B. Magnuson, M.D., chief medical director of the Veterans' Administration, recently announced that osteopaths now are authorized to provide, on a fee basis, out-patient treatment (within certain limits) to veterans with service-connected disabilities—when their services are requested by veterans.

* * *

"If the medical profession can be taken over by the federal government and forged into a new and gigantic health bureaucracy, it would only be a question of time until Washington would likewise move into the field of education, religion, the press and radio."—Congressman Harness of Indiana.

* * *

Group Health Association.—The organization in Washington which figured in the AMA's anti-trust suit is having some financial difficulties and its trustees have recommended an increase in rates, but the members in a mass meeting would not endorse the recommendation and instructed the Board to investigate other methods of increasing the income.

* * *

U. S. Public Health Chief.—President Harry S. Truman, has named Leonard A. Scheele, M.D., as Surgeon General of the United States Public Health Service. Dr. Scheele was formerly from Detroit and is a graduate of Wayne University. He served two years as chief of preventive medicine in the European Theatre under General Eisenhower.

* * *

U. S. measure to aid public health agencies.—S.-2189 was introduced late in February by Senator Saltonstall of Massachusetts to bolster local public health agencies by giving them federal financial support. This measure is strongly backed by Association of State and Territorial Health Officers and National Congress of Parents and Teachers.

* * *

L. J. Gariepy, M.D., Detroit, was recently elected to the Hall of Fame of the Northwestern Council of Detroit. This honor is given annually to the citizens of Northwest Detroit who in the estimation of the Northwestern Council has done the most outstanding work in civic authority from which Northwest Detroit has benefited. Congratulations, Dr. Gariepy!

* * *

Michigan's financial status, according to the Michigan Survey, represents, in one sentence, a total revenue of $382 million and a total expenditure of $371 million for the fiscal year ending July 1, 1947.

The greatest source of revenue is the sales and use tax ($161 million) and the greatest expense is payments benefiting local units ($226 million).

* * *

Morris Fishbein, M.D., Chicago, Editor of *JAMA,* recently was awarded a Certificate of Merit by President Truman in recognition of his "outstanding efforts as Chairman of the Committee on Information of the National Research Council, which proved to be an invaluable contribution to the war effort of the United States." Congratulations, Dr. Fishbein!



Handle More Cases

with extra time and attention for patients using the

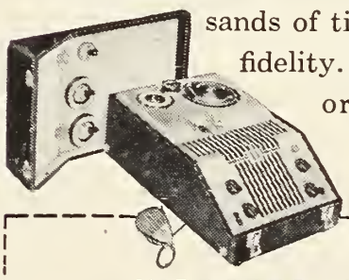
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"The Selling Price of a Medical Practice," which appeared in *JAMA* of January 31, 1948, authored by Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the AMA, Chicago, now is in reprint form. Copies may be obtained by writing Dr. Dickinson at 535 N. Dearborn Street, Chicago 10, Illinois.

* * *

An International Congress on Mental Health will be held in London, England, August 11-21, 1948, under the sponsorship of the International Committee for Mental Hygiene. John R. Rees, M.D., of London, Chief Psychiatric Consultant to the British Army, is President of the Congress. For further details and program, write the Committee at 1790 Broadway, N. Y. 19.

* * *

American Medical Directory. One hundred and fifteen thousand physicians have returned their Directory Information Cards to the American Medical Association, 535 N. Dearborn, Chicago 10, Illinois. Those physicians who have received these cards and have not returned them are urged to do so at once—as the information is needed for individual listings in the 1949 Directory.

* * *

E. F. Sladek, M.D., Traverse City, MSMS president-elect, represented the Michigan State Medical Society at the ground-breaking ceremonies for the Mesick Community Health Center on February 12.

Dr. Sladek spoke to the Traverse City Lions' Club, February 20, on the subject "The Five O'Clock Whistle." He also addressed the Traverse City Exchange Club on Tuesday, February 24. His subject was "Political Medicine."

* * *

The Michigan Society of Anesthetists will hold a dinner meeting at the Olds Hotel, Lansing, on Wednesday, May 19, at 6:30 p.m. The program will consist of a symposium on the treatment of tetanus, with special attention to the management of sedation in cases of tetanus. All doctors of medicine interested in this meeting are cordially invited to attend. For reservations, write Mary Lou Byrd, M.D., Secretary, Butterworth Hospital, Grand Rapids.

* * *

National Health Assembly.—Federal Security Administrator Oscar R. Ewing has announced the formation of a National Health Assembly to be held in Washington, May 1-4, "to develop feasible national health goals for the next ten years." On the Executive Committee of the National Health Assembly is listed George F. Lull, M.D., Secretary and General Manager of the American Medical Association—the only representative of the medical profession.

* * *

Something for Dr. Parran to do?—The Senate has *approved the appointment of Dr. L. A. Scheele* as Surgeon General, to succeed Dr. Parran on April 6. It has been rumored that Dr. Parran will remain with the

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Public Health Service and may be asked to make a survey of public health conditions in Greece or the Philippine Islands; or he may be asked to represent the United States with the World Health Organization if, and when, the Congress decides that the U.S. shall become a member in that organization.

* * *

The Federal budget picture today.—Your watch ticks five times every second. Let it run, day and night, for 6 years and 4 months—and you will have clocked off a billion ticks. At $1 a tick, a watch could count (merely *count,* mind you) the $39.7 billion total asked for in the President's budget message—*if* a watch could be kept running for nearly *252 years.* Think that over, and you get an idea of the size of the jackpot with which Congressional budgeteers are wrestling in Washington right now.—*Michigan Survey,* February 9, 1948.

* * *

More than 900 physicians have pulled out of the San Francisco Health Service System, the compulsory health insurance plan for city employes, because of limits and restrictions imposed by the plan which they contend make it impossible for them to render high quality medical service and because of dictation on medical matters.

Group Health Association, Washington, D. C., is also having difficulty—financial. This is the medical-hospital prepayment group which figured prominently in AMA's anti-trust file in 1941. Members of GHA recently voted to ask the Board to formulate a plan to balance the strained budget.

Hospitals and the Practice of Medicine.—The AMA House of Delegates, at its Interim Session in Cleveland last January, adopted a report asking "that the Board of Trustees appoint a committee to study the various resolutions passed previously by the House (condemning the system whereby hospitals exploit the services of physicians) and that this committee be directed to arrange conferences with the hospital associations and the various specialist societies in order that a solution may be worked out which will be fair to all parties and redound to the benefit of the public."

* * *

Miracle of Living.—The Army has recalled all venereal disease control films that were used during the war and is distributing a new one entitled "The Miracle of Living," which reflects the present program. It reports that as a result of stressing the moral reasons for good conduct, the incidence of venereal disease among American soldiers has had a phenomenal drop. For the Army, as a whole, the decrease amounts to 40 per cent since January, 1947; and among soldiers stationed in the United States, the decrease totals more than 50 per cent for the same period of time.

* * *

The Kent County Medical Society will open a community blood bank in Grand Rapids, next autumn, according to a recent announcement. The project will replace the present system in which major hospitals of Grand Rapids obtain their own blood for their patients. The project was initiated with the co-operation of



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SURGERY—Intensive Course in Surgical Technique, two weeks, starting April 12, May 10, June 7.
Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting April 26, May 24, June 21.
Surgical Anatomy & Clinical Surgery, two weeks, starting April 12, May 10, June 7.
Surgery of Colon & Rectum, one week, starting April 26, May 24.
Surgical Pathology every two weeks.
UROLOGY—Intensive Course, two weeks, starting April 12.
FRACTURES & TRAUMATIC SURGERY—Intensive Course, two weeks, starting June 7.
OPHTHALMOLOGY—Intensive Course, two weeks, starting May 10.
Ocular Fundus Diseases, one week, starting June 7.
GYNECOLOGY—Intensive Course, two weeks, starting April 26, June 7.
Vaginal Approach to Pelvic Surgery, one week, starting April 19, June 21.
OBSTETRICS—Intensive Course, two weeks, starting April 12, June 21.
MEDICINE—Intensive Course, two weeks, starting April 26.
Personal Course in Gastroscopy, two weeks, starting June 28, July 12.
Electrocardiography & Heart Disease, four weeks, starting May 3.
Hematology, one week, starting May 10.
Gastroenterology, two weeks, starting May 24.
DERMATOLOGY—Formal Course, two weeks, starting April 26.
Clinical Course every two weeks.
ROENTGENOLOGY—Every two weeks.

General, Intensive and Special Courses in all Branches of Medicine, Surgery and the Specialties

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Blodgett Memorial, Butterworth, and St. Mary's Hospitals. The Kent County Medical Society's Blood Bank Committee, chairmanned by Edward S. Ducey, M.D., is completing the arrangements. The Blood Bank Headquarters will be at the same location as the Cancer Detection Center.

* * *

The Marshall Plan will probably be approved this summer, and will continue in operation for five or six years. The advertised sum to be spent is 20 billions of dollars, but that is probably just the beginning. Much of the benefits will go to Great Britain, where a socialistic government is now completing the socialization of the medical profession. Why must we in America contribute in such prodigious amounts to a government whose economic and social outlook is diametrically opposed to our own? Could an amendment be placed on the plan limiting its benefits and especially its expenditures to non-socializing processes? Letters to our Congressmen expressing this idea would do no harm, at least.

* * *

Regional Meeting.—The American Federation for Clinical Research held a regional meeting at the Wayne County General Hospital, March 5, 1948. The topics for presentation numbered twenty-three. Each speaker was allowed ten minutes, with three minutes allowed for discussion. The speakers came from the Wayne County General Hospital, the University of Michigan, Harper Hospital, Alexander Blain Hospital, Wayne University, Parke, Davis and Company, Henry Ford Hospital, and Toledo. The guest speaker, after dinner, was Frank Wilson, M.D., Ann Arbor, Professor of Medicine at the University of Michigan. His topic: "The Support of Medical Research." Approximately 150 men from Michigan and Northern Ohio attended.

* * *

Status Quo of Social Security.—In accordance with a decision of the Supreme Court, the Department of Internal Revenue extended the Social Security coverage to probably 750,000 people who were not eligible prior to this action of the Court. The House considered and adopted a joint resolution (H.J.Res. 296) which *re-establishes the definitions* of "employer" and "employe." It was argued that, under the Court's definition, self-employers and operators of private businesses might be required to register with the Social Security Bureau. Examples given were insurance agents and Fuller Brush salesmen. Proponents of the resolution stated that, when social security coverage was to be extended, appropriate legislation should be indicated rather than attempting to have it done through Court decision.

* * *

George F. Lull, M.D., secretary and general manager of the AMA, published the following warning in his Secretary's Letter of February 23:

"Warn against enrollment in foreign medical schools. One of the speakers at the Federation of State Medical Boards, meeting in Chicago recently, deplored the fact that the Veterans Administration had now approved foreign medical schools which veterans could attend under the GI Bill of Rights.

"He sounded a stern warning that graduate students

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of these schools faced eventual disappointment because they would not be eligible for licensure in the United States.

"It might be well for physicians to pass this warning along to any veteran contemplating medical study abroad."

* * *

Paul R. Hawley, M.D., former Medical Director of Veterans Administration and now Executive Director of the Blue Cross Commission and the Associated Medical Care Plans, since April 1, recently made the following statement: "I have been told by so-called experts that this undertaking is too gigantic for a private, voluntary agency and that only the government is in a position to make it successful. I would have no quarrel with this point of view except that it is invariably coupled with the provision that, to make it successful, the government would have to control the practice of medicine. Nor would I object to the government control of medicine if this would elevate the standard of medical practice in this country. But I have seen government medicine in operation in other countries and I know what government control does to medicine. I want no part of it for our people."

* * *

You're In—You're a Veteran.—Frederick W. Taylor, M.D., of Indianapolis, Indiana, is the author of an article with the above caption in the February number of *Harper's Magazine,* in which he states that 80 per cent of veterans in Veterans Administration Hospitals are there for non-service-connected disabilities. This is now legal by rulings, and no one has the courage to change the condition because of pressure groups and votes. The veteran must sign form P-10, stating that he cannot afford to pay. There is a penalty for false statements, but no personnel to check on the statements. With the veterans numbers growing constantly, now over 18,000,000, that makes complete medical and hospital care for a large percentage of the population, and gives a preview of what is to come when we have complete health care for all. The cost in these hospitals is now over $15.00 per day.

* * *

The Bay County Medical Society (Michigan) conducted a Cerebral Palsy Clinic on Wednesday, March 17, in co-operation with the Michigan Society for Crippled Children and Disabled Adults and the Bay County Chapter for Crippled Children. Meyer A. Perlstein, M.D., Chicago, conducted the clinics in both the morning and afternoon and addressed the Bay County Medical Society and guests at the dinner meeting at the Wenonah Hotel. One hundred and sixty-eight persons were present.

Bay City, Michigan, may become nationally recognized as the birthplace of the Junior Red Cross movement. William Kerr, M.D., retired Bay City doctor of medicine, was largely responsible for development of the movement and for promoting it on a national plane—in 1917 when Dr. Kerr was chairman of the Bay County Red Cross Chapter. Dr. Kerr's letter of April 24, 1917,



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suggesting that school children could be used in Red Cross work, resulted in President Woodrow Wilson's issuing a proclamation, on September 15, 1917, making Junior Red Cross an official part of National Red Cross.

* * *

At the invitation of the Michigan Hospital Association, The Council of the Michigan State Medical Society appointed a committee of five, representing the Michigan State Medical Society, to meet with similar committees of the Michigan Hospital Association and of the Michigan State Nurses Association to study the problem of proper nursing service. Personnel of the MSMS Committee to the joint committee of 15 are: J. Duane Miller, M.D., Grand Rapids, Chairman; E. C. Baumgarten, M.D., Detroit; C. G. Clippert, M.D., Grayling; E. G. Merritt, M.D., Detroit, and E. A. Oakes, M.D., Manistee.

The Council also appointed a permanent liaison committee with the Michigan Hospital Association to which all other matters (except the problem of nursing service) could be referred in future. This committee is composed of: J. Duane Miller, M.D., Grand Rapids, Chairman; E. C. Baumgarten, M.D., Detroit, and E. A. Oakes, M.D., Manistee.

* * *

U. S. Children's Bureau.—Dr. Samuel M. Wishik has been appointed to the U. S. Children's Bureau of the Federal Security Agency to direct the planning work connected with the Bureau's program of grants-in-aid to the states for maternal and child health, and for crippled children's services.

In announcing the appointment, Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, said that more effective health services are needed for the thousands of babies born prematurely, and the thousands of children suffering with cerebral palsy, rheumatic fever, hearing defects, cleft palates, and many other handicaps.

Dr. Wishik will be concerned with developing standards for and improvements in these health services and thus help the Bureau's field staff and the state health departments make their programs more effective. The Bureau is authorized under Title V of the Social Security Act, to grant $18,500,000 annually to the states for these programs.

* * *

MHS-MMS Reports to the Public on Michigan's Greatest "Public Trust."—Beginning February 2, all newspapers of Michigan featured advertisements of Michigan Hospital Service-Michigan Medical Service with the following banner: "1½ MILLION DOLLARS A MONTH PAID BY BLUE CROSS FOR CARE RENDERED MICHIGAN SUBSCRIBERS."

The advertisement gave the story in brief of the Blue Cross, nationally and in Michigan, showing that the MMS was organized and is operated by the doctors, and MHS by the hospitals; that they are fully non-profit operations and public service; and that they are "truly a public trust, which by strict adherence to principles of non-profit operation, have returned to their members more than 70 million dollars in services for needed hospital, medical-surgical care."

The advertisement contained a statement of the finan-

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cial condition of Michigan Hospital Service and Michigan Medical Service, known as "The Blue Cross Plans."

Congratulations, Michigan Hospital Service-Michigan Medical Service, on this report to the people on Michigan's Greatest Public Trust!

* * *

Rural Health Scholarships.—The following states offer a certain number of scholarships to attract physicians to their states:

Kentucky—More than $150,000 was raised for this purpose in a campaign sponsored by the Kentucky State Medical Association and the University of Louisville School of Medicine.

Indiana—The Indiana State Medical Association offers six $500 scholarships annually, available only to residents of Indiana.

Alabama—provides for one $400 scholarship for each of the 67 counties of the State.

Wisconsin—is sponsoring a bill under which physicians would be appointed as Special Medical Officers, at $1800 a year, for part time public health service.

South Carolina—The House of Representatives of South Carolina, last May, approved the establishment of 14 scholarships, valued at $550 a year, at the State Medical College.

Mississippi—The Mississippi State legislature appropriated $300,000 in 1946, for similar scholarships, with a maximum loan to students of $1,250.

Virginia—The University of Virginia Medical School has ten scholarships, worth $550 each, for students who will practice in rural areas.

* * *

Will Heart Disease Get You?—The *American Legion Magazine* for February, 1948, has an article by Myron Stearns telling about the effect of heart disease, which killed 587,000 in 1945. There are four great killing diseases; the second is cancer with 177,000 deaths; third, tuberculosis with 53,000 deaths, and fourth, poliomyelitis, 1,186 deaths in 1945. The public interest in these diseases, and their prevention was in reverse. $16,000,000 for infantile paralysis, $15,500,000 for tuberculosis, $4,000,000 for cancer and $39,000 for heart disease. The American Heart Association is striving to raise money this year to further prevention and research. One cause is rheumatic fever, which the Michigan State Medical Society, with the co-operation of the Michigan Society for Crippled Children and Afflicted Adults is studying. The final paragraph reads:

"In 1940, $525 was available for each case of infantile paralysis; $2.13 for each cancer case, and *17 cents* for each heart disease patient. In 1945, the amounts contributed to the leading health associations worked out as follows: to the National Foundation for Infantile Paralysis, $13,490.72 for each death from polio; to the National Tuberculosis Association, $299.92 for each death from tuberculosis; to the American Cancer Society, $22.54 for each death from cancer; and to the American Heart Association, *seven cents* for each death from heart disease. Brother, do you want to live?"



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New Ten-Year Health Program—The Federal Security Agency has called a National Health Assembly for May 1, 1948, in Washington, according to news reports of March 2. As so many times in the past when National Health Conferences are set up by the Government, the persons really qualified to speak are among the missing.

This list contains just one doctor of medicine, Dr. George F. Lull, secretary of the American Medical Association. Others are Mrs. Mary Lasker, a member of Michael Davis's lobbying outfit, the "Committee for the Nation's Health"; Mrs. Anna M. Rosenberg, formerly regional director of the Social Security Board; Mrs. Eugene Meyer, who has been working for the establishment of a Welfare Department with Oscar Ewing of the FSA in the Cabinet; Elizabeth Christman, secretary-treasurer of the National Women's Trade Union League; Walter White, secretary of the National Association for the Advancement of Colored People; Oscar Ewing, of the Federal Security Agency; Isadore Falk, A. J. Altmeyer, labor leaders. Representatives of press and radio and the president of the U. S. Chamber of Commerce make up the twenty-four leaders in health work.

This movement is a continuation of the plan reported by us last month when the President sent a letter to Oscar Ewing asking that studies be made for a Decade of Advancement in Health. He admitted that some progress had been made in this country. "But I am convinced that we have scarcely scratched the surface,

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and that, as a Nation, we can make rapid progress in the immediate future." What a flattering opinion of medical and health progress up to date! And his opinion of medicine in general is shown by appointing only one doctor on the Committee of Experts. Who in the name of common sense will be responsible for the "rapid advance of the future?"

NOTE: Since this item was written, a member of the Board of Trustees of the A.M.A. and Dr. Paul R. Hawley, National Executive Director of Blue Cross and Blue Shield, have been added to the Executive Committee.—EDITOR.

ERRATUM

Apologies to Dr. M. Mary Rohn, Polk State School, Polk, Pennsylvania, for running obituary notice on page 100, January, 1948, issue of THE JOURNAL, MSMS. Apparently our source of information, clipping from the Brighton, Michigan, *Argus,* Wednesday, November 19, 1947, was very much in error. We have received word from Doctor Rohn to the effect that she is living and in good health and is employed at the Polk State School, Polk, Pennsylvania. We wish Doctor Rohn many more years of life, because we know that the world has need of excellent physicians.

To prevent reprinting of inaccurate news articles in THE JOURNAL, all obituaries hereafter will be cleared through the County Medical Societies. This will mean a delay in getting death notices to our members. However, we must have the story right before it is set in type.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

BABY CARE FROM BIRTH TO BIRTHDAY. By Edmund G. Laaler, M.D., Associate in Pediatrics, Loyola University School of Medicine; Chairman, Pediatric Department, Little Company of Mary Hospital, Evergreen Park, Ill.; Licentiate, American Board of Pediatrics; Fellow, American Academy of Pediatrics. Chicago—New York—Toronto: Wilcox and Follett Co., 1948.

This is a handy little book, good reading size, light, well and clearly printed. It answers every possible question about the baby, during his first year of life, and illustrates the point with over 200 photos. Every care, changing and dressing, bathing, feeding, taking the temperature, all are illustrated. This book is written for the mother who wishes to take proper care of her baby, and offers all needed help. Nursing, feeding, preparation of formulae, and the details involved are all meticulously given. Such a book would be of inestimable help to the new mother. It takes the life of the baby each month of its first year, tells what to expect, how the baby may have, or should have, progressed, and is a guide to good care. It tells the mother, when calling the doctor, to have a pencil and paper so as to take down directions, so no mistake will be made. Much space is given to cautions about foreign bodies and what to do to relieve the baby of them. A most valuable book.

RECENT ADVANCES IN MEDICINE—Clinical, Laboratory, Therapeutic. By G. E. Beaumont, M.A., D.M. (Oxon.), F.R.C.P. (Lond.), Physician in the Middlesex Hospital; Physician to the Hospital for Consumption and Diseases of the Chest; Lecturer in Medicine, Middlesex Hospital Medical School, and E. C. Dodds, M.V.O., D.Sc., Ph.D., M.D., F.R.C.P., F.R.I.C., F.R.S. (Edin.), F.R.S. Courtland Professor of Biochemistry in the University of London. Director of Courtland Institute of Biochemistry, Middlesex Hospital. Twelfth edition. 42 illus. Philadelphia and Toronto: The Blakiston Company, 1947. Price $6.00.

Much new material has been added to the methods and processes used in the practice of medicine since the first edition of this book in 1924, and in this edition about 100 new pages are added. A chapter on penicillin is new, also articles on thiouracil, sex hormones, infectious jaundice, atypical pneumonia, blood analyses and blood storage. It is a practical book, with sufficient on the subject but not an overabundance, making it very useful.

DISEASES OF THE NOSE, THROAT AND EARS. By William Lincoln Ballenger, M.D., F.A.C.S. Late Professor, School of Medicine, University of Illinois, Chicago, and Howard Charles Ballenger, M.D., F.A.C.S., Associate Professor and Acting Chairman of the Department of Otolaryngology, Northwestern University School of Medicine, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois; assisted by John Jacob Ballenger, B.S., M.D., Research Fellow in Otolaryngology, Northwestern University School of Medicine, Chicago. Ninth edition, thoroughly revised. 597 illus.; 16 plates. Philadelphia: Lea & Febiger, 1947. Price $12.50.

Ballenger's text has been a standard book for many years, and a ready reference whenever needed. It has been

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revised and reissued, but the present edition is most liberally changed. Much old material is removed, many of the illustrations are new, and much new material is added. The chapter on the auditory sense is worth the whole book. The new work on restoring hearing in otosclerosis is well written, clearly illustrated. The Lempert operation is described, and several others on the labyrinth. A chapter on physiology and functional tests of the labyrinth by Alfred Lewy, M.D., F.A.C.S., is clearly and profusely illustrated with colored plates.

This book is bound to be a favorite with students as well as practitioners.

HERNIA, ANATOMY, ETIOLOGY, SYMPTOMS, DIAGNOSIS, DIFFERENTIAL DIAGNOSIS, PROGNOSIS, AND TREATMENT. By Leigh F. Watson, M.D., F.I.C.S., Los Angeles, Certified by the International Board of Surgery; formerly Associate in Surgery, Rush Medical College, Chicago; formerly Assistant Professor of Surgery, University of Oklahoma Medical School, Oklahoma City. Third edition, enlarged and thoroughly revised. 325 illustrations by Helen Lorraine; Willard C. Sheppard; Ralph Sweet. St. Louis: The C. V. Mosby Co., 1948. Price $13,50.

The new third edition of Watson's "Hernia" has been thoroughly revised and brought up to date. It is the Standard American work on hernia. The subject is covered completely and concisely from anatomy to treatment. The operations which have stood the test of time are described in detail, omitting the myriad confusing minor modifications in technique.

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gical treatment is repair of that fascia suitably re-inforced by more superficial layers, that fascia should be sutured to fascia and without tension.

The Cooper's ligament operation which is coming into increased and deserved prominence is given detailed description. The soundness of its fundamental principles, long used by the reviewer and with increasing satisfaction, is gaining rapid recognition.

Our only criticism is that the illustrations do not show an incision through the floor of the inguinal canal and the complete exposure of Cooper's ligament. Sutures are placed into Cooper's ligament through the floor of the canal. In inexperienced hands this might lead to injury of the femoral vein. Others might think from the illustration that the transversalis fascia is merely sutured to the floor of the inguinal canal.

Comprehensive chapters are devoted to the more rare varieties of hernia. The injection treatment is given in detail. Excellent illustrations help to make this a book that should be in the library of every surgeon.

A. R. D.

ULCER. The Primary Cause of Gastric and Duodenal Ulcer, Diagnosis, Medical and Surgical Treatment, Prevention. By Donald Cook, B.A., M.D. Chicago: Medical Center Foundation and Fund, 1947.

This book is a development from ten meetings of the Annual Symposium on the Primary Causes of Gastric and Duodenal Ulcer. The study is complete, well presented and concise. The book is very readable, not too large, and makes a ready reference when studying this subject.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Ethics — Fee Splitting — Rebates

PRINCIPLES OF MEDICAL ETHICS

The Executive Committee of the Council, Michigan State Medical Society, apropos the rebate charges mentioned in the last number of THE JOURNAL (see editorials), has instructed the Editor to publish in THE JOURNAL, the Principles of Ethics of the American Medical Association, and the law of the State of Michigan covering this subject. It is suggested that appropriate measures have already been taken to avoid whatever is unethical or illegal in the practice of the profession, and the belief is strong that many of our members probably do not have a copy of either of these two documents.

The Principles of Ethics are covered by copyright in 1937, and permission to publish is contained in the following letter from the Secretary and General Manager of the A.M.A.:

"You are at liberty to publish this in your Journal, provided credit is given the American Medical Association. These Principles are in process of revision. The Principles themselves have not been changed. The revision will not be complete until after the House of Delegates has acted on it. (Signed) George F. Lull."

Principles of Medical Ethics, AMA

CHAPTER I

In General

THE PHYSICIAN'S RESPONSIBILITY

SECTION 1.—A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

GROUPS AND CLINICS

SEC. 2.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors, each of whom, whether employer, employe or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

CHAPTER II

The Duties of Physicians to Their Patients

PATIENCE, DELICACY AND SECRECY

SECTION 1.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 2.—A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

PATIENTS MUST NOT BE NEGLECTED

SEC. 3.—A physician is free to choose whom he will serve. He should, however, always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

CHAPTER III

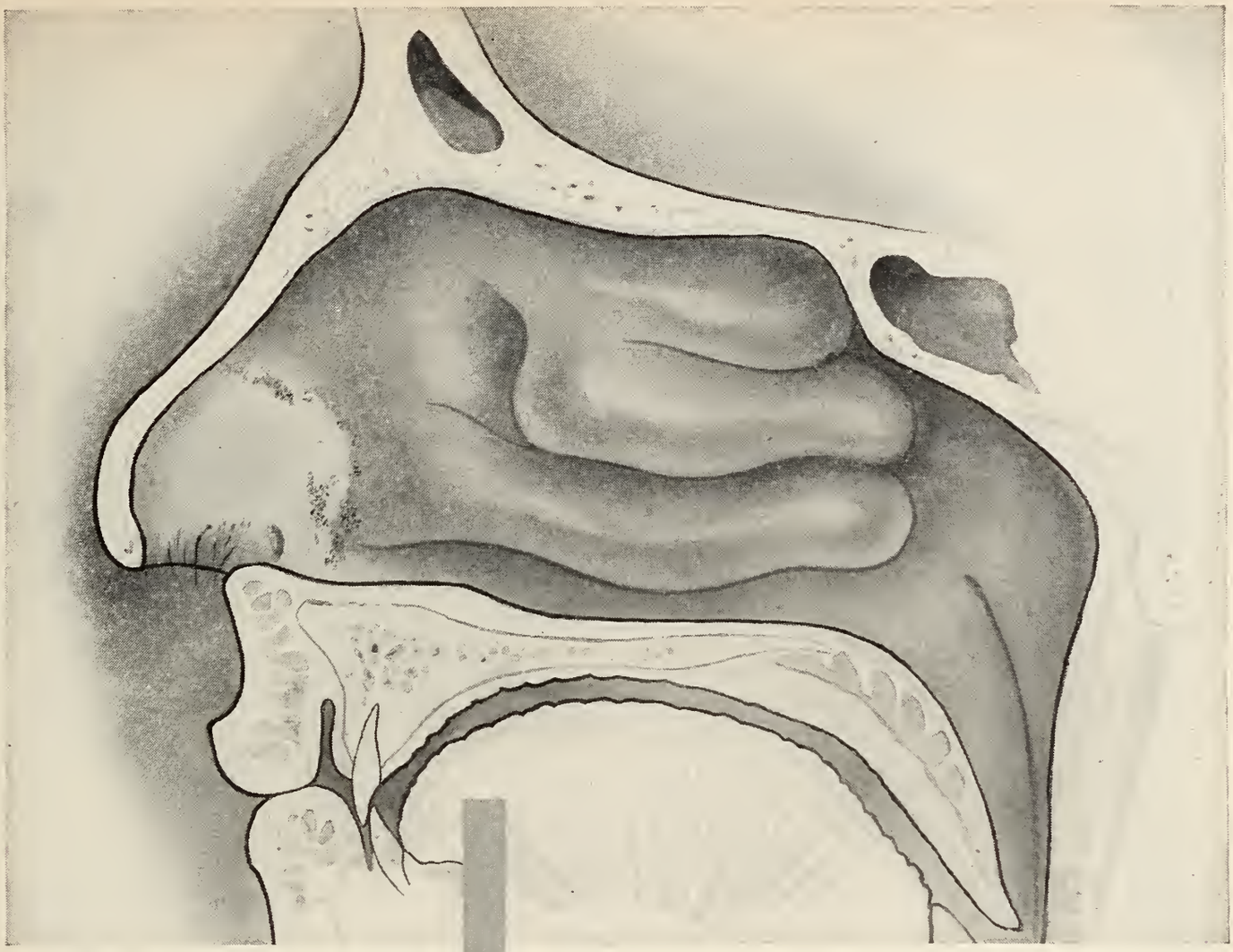
The Duties of Physicians to Each Other and to the Profession at Large

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLD HONOR OF PROFESSION

SECTION 1.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable

(Continued on Page 468)



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Principles of Medical Ethics

(Continued from Page 466)

means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought." (Nicon, father of Galen.)

MEDICAL SOCIETIES

SEC. 2.—In order that the dignity and honor of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

DEPORTMENT

SEC. 3.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates.)

ADVERTISING

SEC. 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

PATENTS AND PERQUISITES

SEC. 5.—It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients.

MEDICAL LAWS—SECRET REMEDIES

SEC. 6.—It is unprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine; it is equally unethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

SAFEGUARDING THE PROFESSION

SEC. 7.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

PHYSICIANS DEPENDENT ON EACH OTHER

SECTION 1.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN TO TAKE CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select a physician from among his neighboring colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

(Continued on Page 470)

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1. Zondek, H.: The Diseases of The Endocrine Glands, ed. 4 (Second English), Baltimore, Williams & Wilkins Company, 1944, p. 421.

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Principles of Medical Ethics

(Continued from Page 468)

Article III.—Duties of Physician in Consultations

CONSULTATIONS SHOULD BE ENCOURAGED

Section 1.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

Sec. 2.—In every consultation, the benefit to be derived by the patient is of first importance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted beween consultants.

PUNCTUALITY

Sec. 3.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered, under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO SPECIALIST

Sec. 4.—When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient, under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

DISCUSSIONS IN CONSULTATION

Sec. 5.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent; and no opinions or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

ATTENDING PHYSICIAN RESPONSIBLE

Sec. 6.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and the subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

CONFLICT OF OPINION

Sec. 7.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

Sec. 8.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

Article IV.—Duties of Physicians in Cases of Interference

MISUNDERSTANDINGS TO BE AVOIDED

Section 1.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

Sec. 2.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit be made, there should be no inquiry relative to the nature of the disease or comment upon the treatment of the case, but the con-

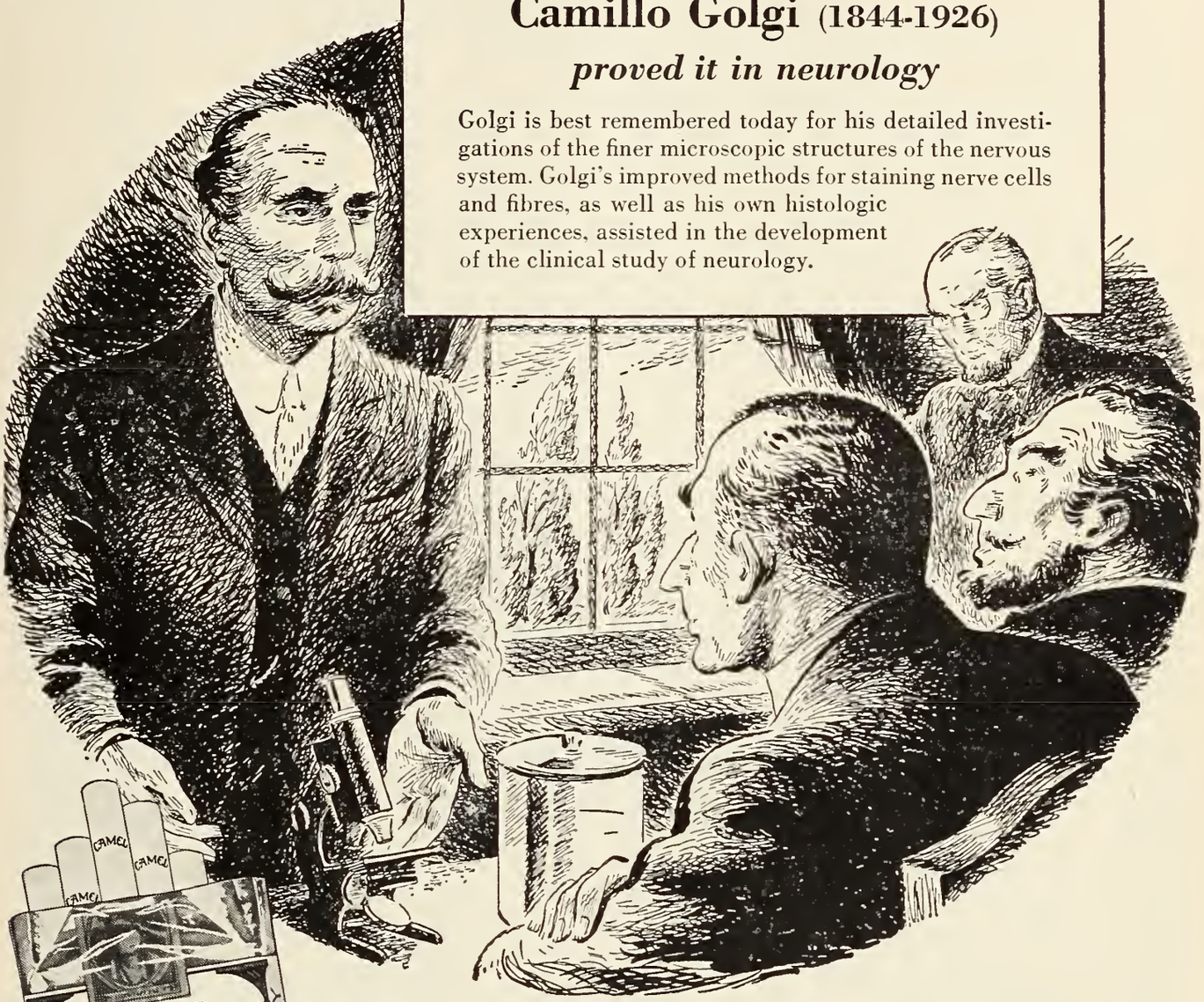
(Continued on Page 472)

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Principles of Medical Ethics

(Continued from Page 470)

versation should be on subjects other than the physical condition of the patient.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favor of the chosen attendant; should the patient or his family wish some one other than the physician known to be the family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

RELINQUISHING PATIENT TO REGULAR ATTENDANT

SEC. 8.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

SUBSTITUTING IN OBSTETRIC WORK

SEC. 9.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DIFFERENCES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTION 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

CONTRACT PRACTICE

SEC. 3.—By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied

(Continued on Page 474)

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to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

COMMISSIONS

SEC. 4.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

DIRECT PROFIT TO LAY GROUPS

SEC. 5.—It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

CHAPTER IV

The Duties of the Profession to the Public

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

PUBLIC WARNED

SEC. 3.—Physicians should warn the public against the devices practiced and the false pretensions made by charlatans which may cause injury to health and loss of life.

PHARMACISTS

SEC. 4.—By legitimate patronage, physicians should recognize and promote the profession of pharmacy; but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substitutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favorable consideration of the public and physicians.

CONCLUSION

While the foregoing statements express in a general way the duty of the physician to his patients, to other members of the profession and to the profession at large, as well as of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him.

Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

MICHIGAN LAW PROHIBITING FEE SPLITTING

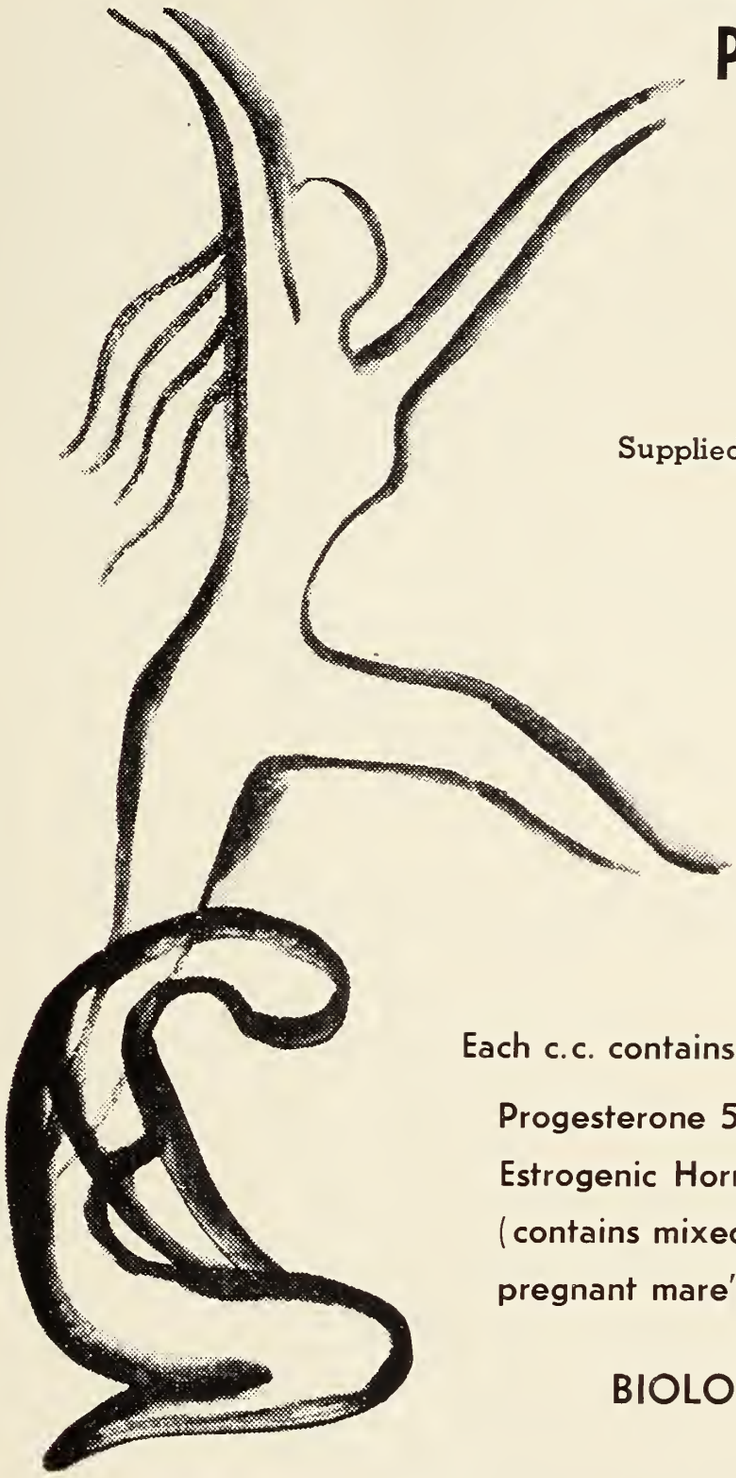
Section 428 of the Penal Code covers the Michigan law prohibiting fee splitting and is treated specifically in Act 328 of the Public Acts of 1931.

Section 428 of the Penal Code reads:

"Sec. 428. Splitting fees. Any physician or surgeon who shall divide fees with or shall promise to pay a part of his fee to or pay a commission to any other phy-

(Continued on Page 476)

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Michigan Law Prohibiting Fee Splitting

(Continued from Page 474)

sician or surgeon or person who calls him in consultation or sends patients to him for treatment or operation, and any physician or surgeon who shall receive any money prohibited by this section, shall be guilty of a misdemeanor punishable by imprisonment in the county jail not more than six months or by a fine of not more than two hundred fifty dollars.

"In case a physician or surgeon shall be convicted of violating any of the provisions of this section the board of registration in medicine, upon a first conviction may and, upon a subsequent conviction, shall revoke the license of the person so convicted."

A Supreme Court decision based on this section appears in Volume 177, Michigan, page 327.

REPORT ON REBATING IN CALIFORNIA

Rebating or equivalent schemes which are tantamount to purchasing patients are more frequent throughout the country than is generally suspected by many established radiologists.

The mass migration of doctors to southern California has made the problem of particular importance, especially in Los Angeles County, for new doctors entering the community are scarcely licensed before a "detail" man from a rebating x-ray laboratory calls to explain how he "can pay the rent" on his new office by accepting rebates, and to state, furthermore, that "this is a general custom in the community."

Such practices are not only highly unethical, but their condonement can work a very real hardship on honest radiologists. In the community of Beverly Hills, for instance, which has a population of 30,000, there are now twenty-one radiologists instead of the three who were present before the war. As if this were not sufficient, two rebating laboratories have recently opened branches in this community.

With the custom of rebating spreading to the degree where recent studies showed 50 per cent of all x-ray and clinical laboratory work to be on this basis, the Better Business Bureau has undertaken a campaign to make the public aware of the situation. This Bureau has been discussing rebates on x-ray and laboratory work and eye glasses for six and a half years with the Council of the Los Angeles County Medical Association. Little progress has been made for several reasons, the chief one of which being that a doctor (himself not a radiologist), who runs the largest rebating laboratory and its three branches, has been extremely interested and influential in County Medical Society politics for a quarter of a century. Minutes of a Council meeting in 1929 unfavorable to rebating have been "lost," and peculiar resistances develop when now and then someone complains that secret rebating should be abolished. No other doctor has displayed such an intense interest in County Society politics for twenty-five years, nor, perhaps, has anyone else stood to make such a personal gain from an interest in County Medical politics.

It is true that so far as numbers are concerned, most rebating laboratories are run by laymen, some of whom are businessmen with no technical training whatever, or by non-members of the County Society. However, such labs could not exist without the patronage of members of the Medical Association.

The most important method of cure for this progressive blight would be a revision of the by-laws of the American Medical Association and its branches. The present obsolete Code of Ethics to which, by the way, all of our x-ray societies refer for final guidance, is filled with loopholes and vagaries. Most important perhaps is the absence of a "grievance" or "ethics" committee, whose function would be equivalent to that of district attorney. At the present time the only way to start proceedings against a member is to have some other member "accuse" him. No one cares to do such "accusing," for it immediately opens the way for the accused to claim that the complaint is but a personal quarrel. How many murderers or burglars would be discovered or convicted if it were up to individual members of the community to look for and then carry on the prosecution?

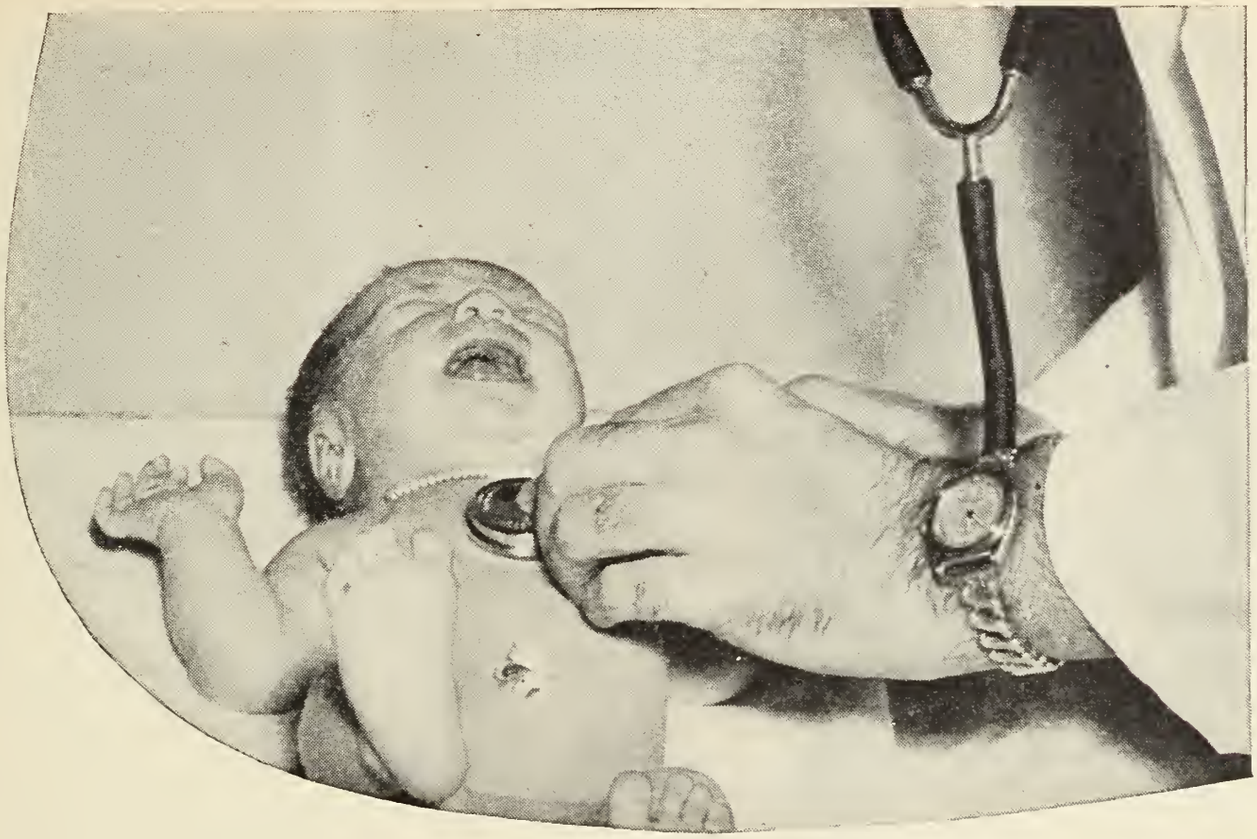
All of our societies including the American Board of Radiology are much in need of by-law revision to make them more workable. With the American Board, for instance, a diploma can be revoked if the holder has been expelled by his County Medical Society or any component x-ray societies who form the Board, if such a society makes formal complaint to the Board. If the offender belongs to none of the societies, however, the Board's by-laws render it powerless to act. At the moment, for instance, a Diplomate of the American Board of Radiology is working for a Chicago lay laboratory. He belongs to no other x-ray societies.

The Better Business Bureau felt that six and a half years of effort with the County Medical Society were enough, and that the best plan of campaign now is to warn the public of rebating practices, for from the business standpoint rebating not only represents unfair competition but can only be done at a sacrifice in quality, or result in overtreatment to obtain extra fees.

The Los Angeles County Medical Association Council had special meetings, and the president of the association signed a pledge in conjunction with Mr. Robert Bauer, manager of the Better Business Bureau. The important part of this pledge, which reads as follows, was ratified by the Council over the objections of a few of the members of this body who have always been interested in rebating practices:

"This means there shall be no rebates to doctors, regardless of the source, but specifically including rebates from the following: Dispensing opticians, funeral directors, clinical laboratories, x-ray laboratories, pharmacies, sellers of glass eyes, artificial limbs, and firms renting oxygen tents and hospital equipment."

The biggest problem at the moment is to make certain that as the smoke of battle clears, quiet but definite policing operations are instituted so that the evil does not again break out, while, at the same time, steps are taken to put appropriate laws through the state legislature to regulate not only the doctors but many others who have been indulging in these practices.—Wilbur Bailey, M.D., *News Letter,* American College of Radiology, Feb. 1948.



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Cancer Comment

THE HILLSDALE PLAN

The survey of cancer incidence and prevalence conducted in Hillsdale County during the summer of 1947 by the Cancer Control Committee of the Michigan State Medical Society revealed the fact that in 50 per cent of the cancer patients seen by the physicians of that county during 1946 the neoplasm was located in organs that were readily accessible for examination and diagnosis. These sites, the skin, breast, uterus and rectum, were also those that offered the greatest hope for cure when cancer of those sites was found in early stages.

The survey also showed that 47 per cent of the cancer patients seen by the physicians during 1946 were dead when the survey was made seven months later.

Only 15 per cent of the 146 cancer patients studied had reported to a physician within one month after the onset of symptoms.

Forty-six per cent of those who delayed thought their symptoms were insignificant or feared serious findings.

These simple facts revealed the need for more effective methods of finding cancer in early stages and posed a problem for the physicians of Hillsdale County to develop a plan for rendering this service. The local unit of the American Cancer Society was asking for a cancer detection center but a detection center if set up in the approved manner would require an organization of medical, nursing and lay personnel within the one hospital of the county, a special set of forms for recording the results of the examinations and necessary follow-up information, and possibly the rearrangement of hospital space and facilities to render the required service. To provide and maintain these facilities a considerable financial outlay would be needed. Most of all, it would require each participating physician to plan his work so as to enable him to give the extra time to the examinations made in the detection center.

Realizing that each physician would be seeing many of his own patients in the detection center and that he could give the same service in his own office, the physicians of Hillsdale County agreed to the following plan as the initial step in supplying a cancer detection service to the residents of that county. This program has become known as "The Hillsdale Plan for Tumor Detection."

The Hillsdale County Medical Society announced through a series of articles in the daily press that its members would offer to all women of the county forty years of age and older a semi-annual examination of the skin, breast, uterus and rectum to be made in their private offices at a mutually convenient time. Younger women and men were not excluded but the publicity has been aimed at the group first mentioned.

In co-operation with the County Health Department, which was most helpful in developing this plan, each physician agreed to keep a list of all such examinations on a special blank. At monthly intervals these lists are sent to the health department where a master file is kept. A uniform fee for these examinations has been established which is less than is charged in most cancer detection centers.

Careful records are kept of all examinations, whether findings are positive or negative, and at the end of each year results will be carefully analyzed. An attempt will be made to follow all patients failing to report for subsequent six months visits, either through the health department personnel or their own physicians.

This plan has been in operation since January 1, 1948, and is proving acceptable to both physicians and the public. All available time for this work has been kept filled with appointments. During the first two months of the service, January and February, 269 examinations were made with the finding of five hitherto unsuspected cancers, or 1.8 per cent of those examined. Two of these cancers were in men. This percentage averages well with similar findings from cancer detection centers.

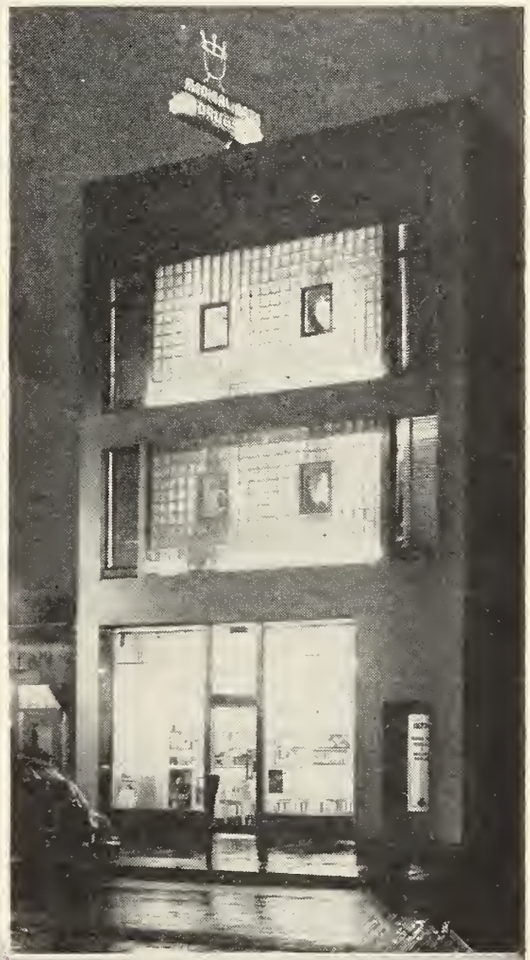
For a rural county with relatively few physicians and restricted hospital facilities, the "Hillsdale Plan" has several advantages, among them conservation of the physician's time which would have to be given to serving a formally organized cancer detection center in addition to maintaining regular office hours. A more satisfactory examination can be made when using familiar office facilities and personnel. Advantage often can be

(Continued on Page 494)

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Michigan Postgradutae Clinical Institute

The registration at the 1948 Institute in Detroit totaled 1,462. The break-down follows:

Doctors of Medicine	1,169
Interns, residents and guests	89
Exhibitors	204
Total	1,462

Out-of-Michigan doctors of medicine who registered included physicians from China, Ontario, Ohio, Indiana, Wisconsin, Kentucky and Missouri. A total of over 28,000 lines of publicity appeared in Detroit and Michigan newspapers in connection with the 1948 Michigan Postgraduate Clinical Institute!

Registration of Doctors of Medicine From Out of Michigan

Indiana.—A. C. Bartholomew, Fort Wayne; R. A. Fargher, LaPorte; W. J. Filipek, South Bend; Elgin P. Kintner, Goshen; D. G. Mason, Angola; W. V. Morris, Monticello; Leo R. Radigan, Gary; P. J. Rosenbloom, Gary.

Ohio.—R. K. Ameter, Bryan; Warren A. Baird, Toledo; P. R. Bauman, Columbus; Horace K. Beckwith, Toledo; J. C. Boyce, Fremont; James I. Collins, Toledo; W. G. Fisher, Columbus; Albert Kostoff, Toledo; Martin R. Lorenzen, Toledo; John A. Mooney, Kenton; Paul F. Orr, Perrysburg; B. D. Osborn, Waldo; H. L. Prouty, West Union; N. C. Schroeder, Kenton; Robert K. Scott, Cleveland; Paul N. Squire, Sandusky; Oliver E. Todd, Toledo.

China.—Tang Hsioh-Hua, Hunan.

Kentucky.—W. C. Cloyd, Richmond.

Missouri.—R. M. Klemme, St. Louis.

Wisconsin.—Robert L. Green, Eau Claire; Ben H. Brunkow, Monroe.

Ontario.—E. C. Armstrong, London; H. W. Baker, Woodstock; G. Berry, Merlin; Quartus Bliss, Kingsville; Norman O. Boyd, Windsor; J. F. G. Colling, Lambeth; S. H. Campbell, Windsor; F. E. Coster, Hamilton; E. A. Currie, Kingsville; D. A. Davidson, Windsor; William R. Davidson, Windsor; J. G. Dignan, Windsor; Harvey Doney, Toronto; G. M. Flock, Windsor; Gordon R. Hall, Woodstock; G. W. Harris, Toronto; Walter E. Henderson, Windsor; R. A. Kennedy, St. Thomas; R. C. Laird, Toronto; F. Douglas Linton, Riverside; J. A. MacLennan, Windsor; B. M. Morrow, Leamington; J. F. Mullins, Windsor; Kenneth Murray, Hamilton; H. R. Nicklin, Leamington; C. W. Pennecott, London; W. C. Powell, Hagersville; Clifford H. Reason, London; Ward Reason, London; Fred I. Reid, Chatham; James Reid, Leamington; Crawford Rose, Aurora; Frederick L. Rose, Windsor; John A. Ross, Kitchener; Glenn Sawyer, St. Thomas; K. B. Schlotzhauer, Stratford; C. B. Solursh, Toronto; A. L. Story, Blenheim; G. K. Trotter, Woodstock; A. T. Wachna, Windsor.

(Balance of the Institute registration will be published in subsequent numbers of JMSMS.)

Unsolicited Comments re the 1948 Postgraduate Institute

Ward Reason, M.D., London, Canada: "Dr. Clifford H. Reason and I wish to extend to you and your colleagues our warmest appreciation of your kindness in inviting us to attend your second Annual Assembly. We wish to congratulate the Institute and Associated organizations on the success which was evident throughout the week. We trust that your institute will have many more such meetings in the future."

R. A. Fargher, M.D., LaPorte, Indiana: "I attended the recent Michigan Postgraduate Clinical Institute, and I want to plan to attend next year's meeting. Let me know at the earliest possible date when the 1949 Postgraduate Institute will be held as I want to plan my time."

Henry F. Vaughan, Dr. P.H., Ann Arbor: "It was a pleasure to have the opportunity of participating in the annual Michigan Postgraduate Clinical Institute. It was a very impressive occasion. I appreciated being there and meeting so many friends."

Wang Pei-Jen, M.D., Central Hospital, Lanchow, China: "A very splendid program from which I gained much."

John DePietro, of Gerber Products Company: "The Michigan Postgraduate Clinical Institute benefited not only the attending physicians but all exhibitors. It is my understanding that pharmaceutical houses and our competitors are fighting to exhibit here. Due to the limited space there is a waiting list; unless someone drops out, which is not likely, competitors will find it difficult to exhibit at this meeting. The Institute was a success from our point of view."

J. A. Reed of Fleet Phospho-soda: "The Michigan medical conventions are the best in the United States. At the recent Postgraduate Institute, the doctors were pleasant and co-operative and registered at booths, something quite unheard of in other sections of the country. It was a pleasure to be with you; put us down for the same space next year."

W. K. Carter, J. B. Lippincott Company: "I want to take this opportunity to thank you, in behalf of Lippincott and myself, for the fine way you ran the Postgraduate meeting. This, of course, is nothing new, for you always do a grand job of handling a meeting, not only from the standpoint of the doctors, but you always give the exhibitors that extra break they need to make a meeting pay off."

Clinical Laboratories

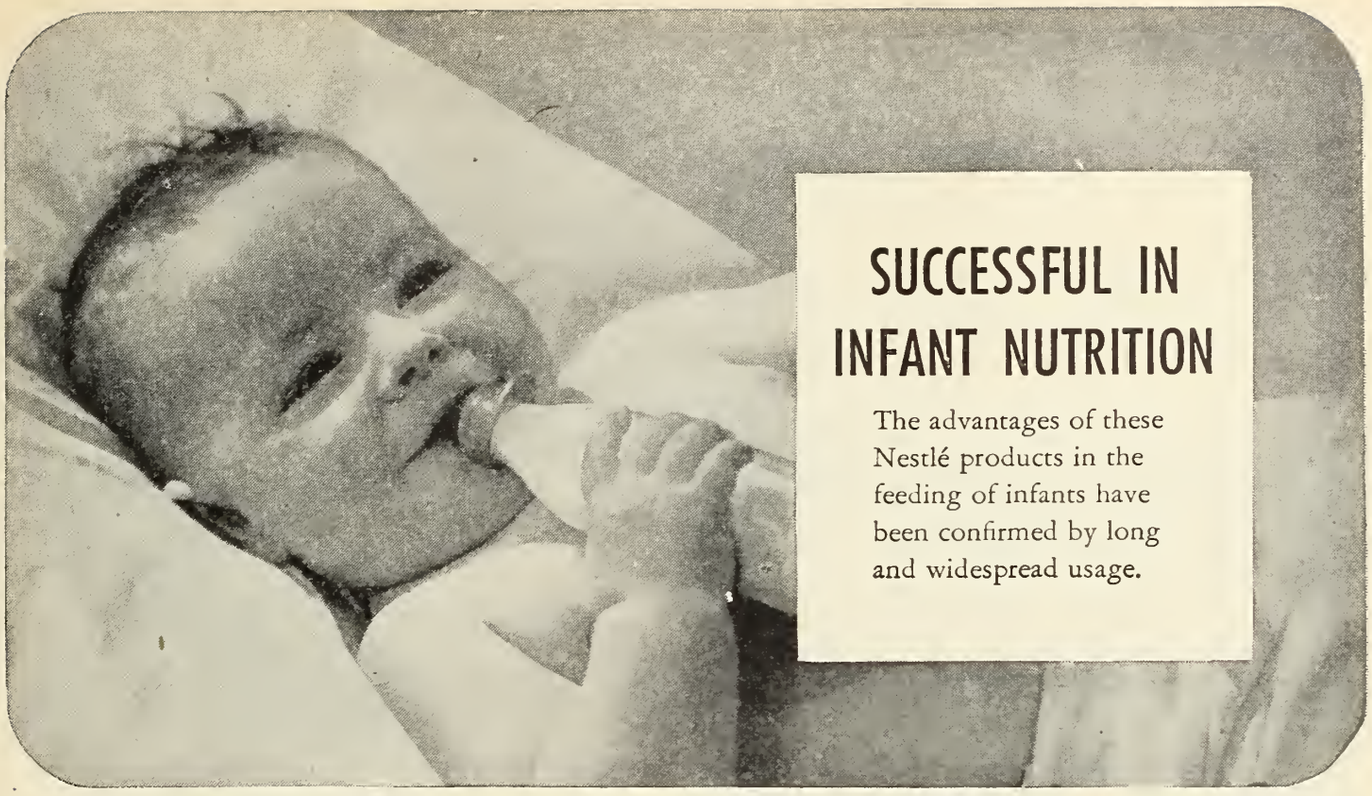
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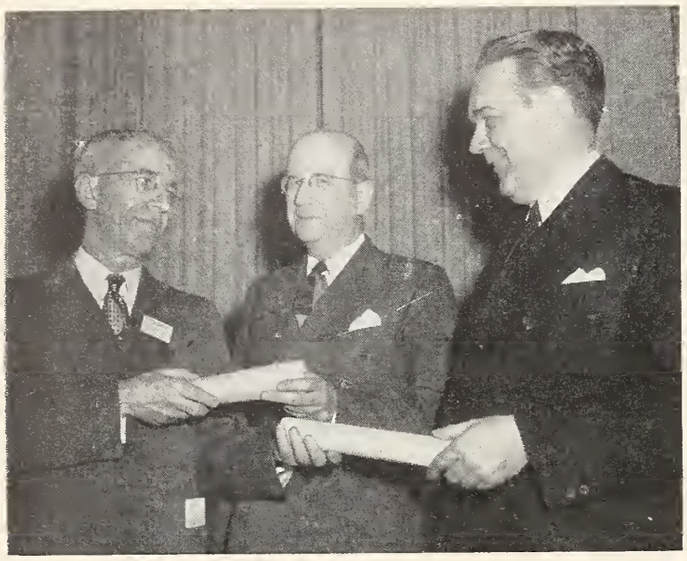
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City_____ Zone_____ State_____

Health Service Awards Presented

The Kellogg Foundation was given the Distinguished Health Service Award by the Michigan State Medical Society on March 11, 1948.

At the same time, on the occasion of the second annual Michigan Postgraduate Clinical Institute, Emory L. Morris, D.D.S., Battle Creek, President of the W. K. Kellogg Foundation, and Henry F. Vaughan, Dr. P.H., Ann Arbor, Dean of the School of Public Health, University of Michigan, were presented with MSMS Health Service Awards by P. L. Ledwidge, M.D., President of the Michigan State Medical Society.



PRESENTATION OF MSMS HEALTH SERVICE AWARDS TO EMORY L. MORRIS, D.D.S., AND HENRY F. VAUGHAN, DR. P.H., IN DETROIT, MARCH 11, 1948.

Left to right: P. L. Ledwidge, M.D., Detroit, President Michigan State Medical Society, Dr. Vaughan and Dr. Morris.

The scroll presented to the Kellogg Foundation read:

In recognition of its
outstanding contribution to the cause of health,
the
MICHIGAN STATE MEDICAL SOCIETY
hereby awards to the
W. K. KELLOGG FOUNDATION
the
DISTINGUISHED HEALTH SERVICE
AWARD

The W. K. Kellogg Foundation has greatly benefited the people of the state of Michigan by the support of medical and health education, public health services, hospital construction and services, and public instruction in health.

Awarded this 11th day of March, 1948.

P. L. LEDWIDGE, M.D., President
L. FERNALD FOSTER, M.D., Secretary

On the Doctors Morris and Vaughan scrolls, the phraseology was:

This
HEALTH SERVICE AWARD
is presented
for valued service rendered to the health of the people; for creative thought and constructive effort in the cause of humanity.

Awarded this 11th day of March, 1948
by the
MICHIGAN STATE MEDICAL SOCIETY

At the presentation, T. E. DeGurse, M.D., Michigan's Foremost Family Physician, was guest of honor.



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You and Your Business

EXECUTIVE COMMITTEE OF THE COUNCIL

Digest of Major Actions at Meeting of March 9, 1948

• Monthly financial reports studied and approved. Bills ordered paid.

• Funds of the Trusteeship between the Michigan State Medical Society and Wm. A. Hyland, M.D., Trustee (dissolved by The Council in January, 1948) were transferred by Dr. Hyland to the Michigan State Medical Society.

• Proposed Hospital Licensing Bill. The following letter was authorized to be sent to Governor Kim Sigler:

> "As you may recall, the Michigan State Medical Society gave early and vigorous support to state legislation to qualify Michigan hospitals for benefits under the Federal Hospital Survey and Construction Act (Hill-Burton Act).
>
> "Since the adoption of the Michigan Enabling Act (Act 299, P.A. 1947) we have been under the impression that its provisions are sufficient to satisfy the requirements of the Federal law.
>
> "Lately, however, we are informed that some doubt has arisen as to sufficiency of the state act. Naturally, if Act 299 needs some minor changes to qualify our hospitals for Federal grants, we hope the Legislature will make them. To do so, however, it does not seem necessary to amend the act by requiring all hospitals in Michigan to be licensed.
>
> "If a general licensing law is to be proposed, would it not be better to have it be submitted as a separate measure, at a regular session, and thoughtfully considered on its own merits? Very respectfully yours, Michigan State Medical Society."

• Immunization campaign conducted between February 1 and March 15, 1948, held to be an unprecedented success by J. K. Altland, M.D., of Michigan Department of Health who praised the efforts and co-operation of the medical profession.

• MSMS Committee reports received from (a) Postgraduate Medical Education Committee, (b) Mental Hygiene Committee, (c) Health Survey Advisory Committee, (d) Maternal Health Committee, (e) Committee on Study of Medical Practice Act.

• The Executive Committee of The Council reaffirmed its confidence in and support of the Michigan Health Council and requested the present members of the Health Council to hold an early meeting to plan future activity.

• S.1290. An "alert" re the dangers inherent in this Congressional bill to subsidize medical service in schools—including treatment—was referred to the Secretary for appropriate action.

• The National Health Assembly, called by Federal Security Administrator Oscar Ewing early in May, was discussed as a "curtain raiser" for a compulsory health program.

• The report on the study of medical facilities in Michigan's penal institutions was submitted and referred to all members of The Council for further study.

• A special committee to study MSMS dues structure, following recommendation by Secretary Foster presented to The Council in January, 1948, was appointed.

• Letter of congratulations on new format of JMSMS and its cover was received from J. R. Bruce, Saint Paul publisher. Heavier paper stock on the covers of THE JOURNAL was authorized.

• Opinion on therapeutic abortions was presented, on request, by J. Joseph Herbert, MSMS General Counsel.

• The holding of the second Rural Health Conference was authorized.

CONGRESSIONAL PROPOSALS OF DIRECT CONCERN TO MEDICAL PROFESSION

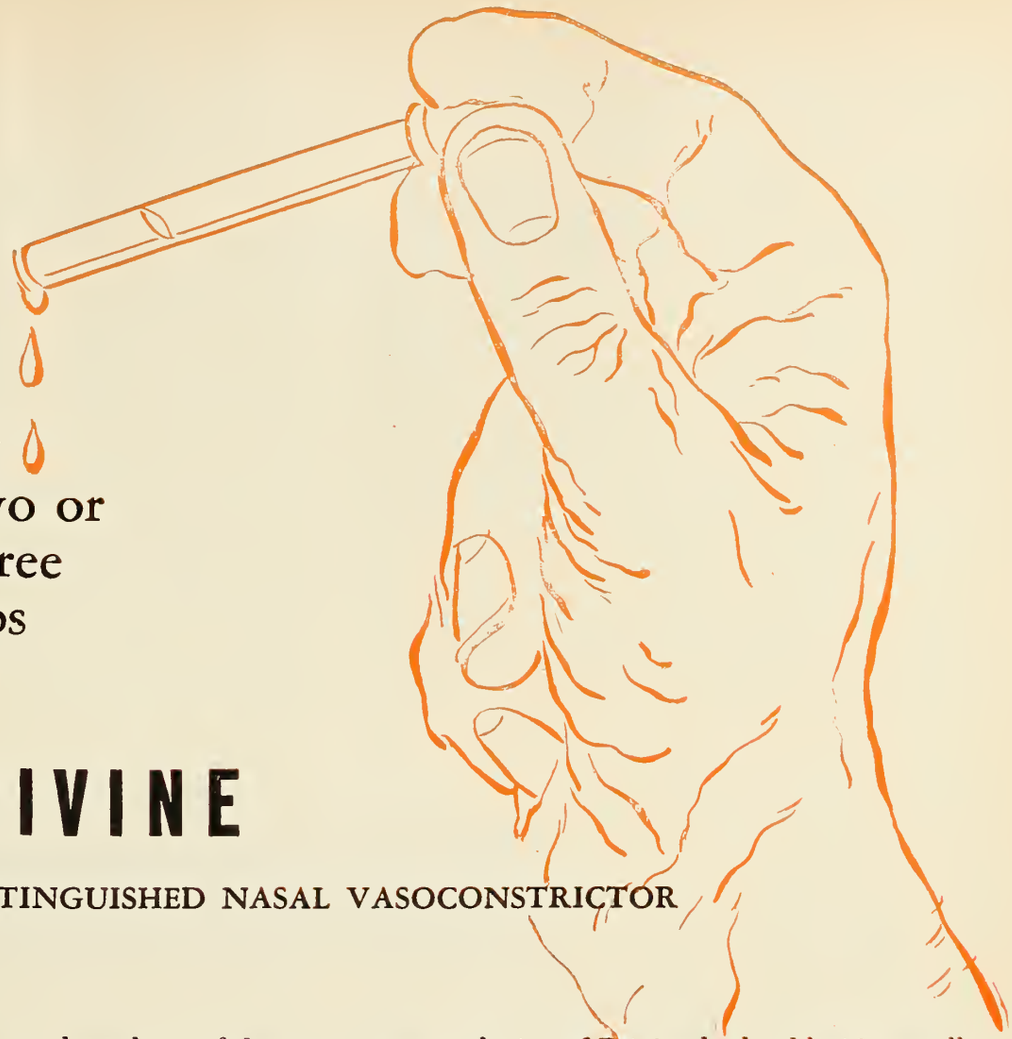
In the United States Congress, the following proposals, if enacted into law, would seriously affect the daily lives of every practitioner of medicine:

1. S.1320, The Wagner-Murray-Dingell Bill
2. S.545, The Taft-Smith-Ball-Donnell Health Bill
3. S.140, introduced by Senator Taft to create a Department of Health, Education and Security. Most medical organizations are opposing this bill because of the fear that in the proposed merger, health would become the "poor relation," subservient to Security.
4. H.R. 1980 and S.1290, to provide financial assistance to states in setting up medical and health service in public schools. These bills bear watching as a limited move toward W.M.D.

BROOKINGS REPORT HITS COMPULSORY HEALTH INSURANCE

In a study reported a few days ago, The Brookings Institution, Washington, D. C., says that compulsory national health insurance would involve too much politics and government control.

(Continued on Page 486)



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high potency Only two or three drops of the 0.05 per cent solution of Privine hydrochloride usually give prompt and complete relief of nasal congestion and hypersecretion.

prolonged action The effect of each application of Privine provides two to six hours of nasal comfort, thus avoiding the inconvenience of frequent re-application.

bland and non-irritating Privine is prepared in an isotonic aqueous solution buffered to a pH of 6.2 to 6.3. Artificial differences in osmotic pressure between solution and epithelium are avoided; stinging and burning are usually absent.

relatively free from systemic effects Although a sedative effect is occasionally noted in infants and young children — usually after gross overdosage — Privine is generally free of systemic effect. The absence of central nervous stimulation permits the use of Privine before retiring without interfering with restful sleep.

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COMPULSORY HEALTH INSURANCE

(Continued from Page 484)

An abstract of the study, carried by the Associated Press to newspapers over the country, quotes the report as saying that it would be wise to leave to the states the question of adopting such a system.

The Brookings report said that for the time being the federal government should direct its aid toward: (1) research; (2) school health education; (3) teaching of preventive medicine; (4) acquiring physical facilities and training personnel, and (5) providing care for the indigent.

Of compulsory health insurance, the report of this private survey organization, which was sent to the senate labor committee, said:

1. Such a system would "necessitate a high degree of governmental regulation and control over personnel and the agencies engaged in providing medical care."
2. "It does not seem probable that politics could be eliminated from medical care supplied under a governmental system."
3. A "real danger" exists that government intervention would impair the relationship of practitioner and patient.
4. Administration "would require thousands of government employes for accounting, auditing, inspection and investigation."
5. "The cost of medical care presumably would increase."

UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES APPROVED IN JACKSON COUNTY

According to H. W. Helmer, Director-Supervisor of the Jackson County Board of Social Welfare, the Jackson County Welfare Department, under date of March 27, 1948, adopted the MSMS Uniform Fee Schedule for Governmental Agencies for indigent persons of Jackson County.

MCCC BILLING

By the 1947 amendments to the Michigan Crippled Children Act, the physician has the privilege of sending his bill direct to the Michigan Crippled Children Commission, Hollister Building, Lansing. Bill monthly, or at the end of the service, in order to insure that the MCCC receives your bill within the time limit (sixty days from the end of the service); if the bill is received after sixty days, the Commission is not permitted by law to pay for the service rendered.

HEARINGS ON NATIONAL SCHOOL HEALTH SERVICES ACT OF 1947

On March 4, 1948, the Subcommittee on Health, of the Senate Committee on Labor and Public Welfare, announced that it would hold hearings on S.1290, on Monday and Tuesday, March 8-9. Dr. James R. Miller, of the AMA Board of Trustees, was given a place on the Tuesday program.

This bill was practically identical with H.R.1980, which Representative Howell introduced in the House. One day of hearings was held on the House Bill last summer. Practically all those who testified favored the measure, but the Committee announced that before it would take action, opportunity to be heard would be afforded to those who might oppose the bill. The lay sponsor of the bill is Mr. Hecht, of the Parents Magazine, and it has the hearty endorsement of the Parent-Teachers Association.

It provides that subsidies be paid the States through the Children's Bureau of the FSA, to "establish and develop school health services for the prevention, diagnosis and *treatment of physical* and mental defects and conditions of children." In some conferences held while the bill was being drafted, the representatives of the AMA expressed agreement with the principle that school children should have the best of medical care, but disapproved of the school authorities providing treatment facilities.

The *first witness was Oscar Ewing,* Administrator of the FSA. He introduced extensive amendments to the bill, quite materially changing its content. For instance, its scope is no longer limited to school children, but broadened to include "all youth of school age," and the program itself is modified to "develop in each state—especially in rural areas and areas suffering from severe economic distress—a comprehensive school health program for the health and physical well-being of all children and youth of school age, pursuant to an integrated state plan which includes the supervision of health instruction and physical education programs, school health services, and school health examinations;" and health examination services is interpreted as meaning "those activities of physicians, dentists, nurses, teachers and other professional personnel."

The amendment also removes the Children's Bureau as an authority and places the full administrative function with the Administrator of the FSA. The personnel of the National Advisory Committee on Health Services, of twelve members, which the original bill provided the President should appoint, in the amendment are to be appointed by the Federal Security Administrator and to include in their number three doctors of medicine and "at least three members of the educational profession." The appropriation allotted is to be increased from ten to twelve million dollars, in order to take care of the added physical education program.

Dr. Martha Eliot, of the Children's Bureau, was the second witness, and urged the endorsement of the bill as amended. In her statement, she said, "Using the most conservative estimates we have, for example—we are faced with four million children with visual defects, one million with hearing defects, 500,000 with orthopedic and plastic defects, 500,000 with rheumatic fever and heart disease, and 200,000 with epilepsy. She deplored the failure of school health examinations, in 33 states, to provide the Bureau with good data on the condition of children." Her idea is that the Bureau should be

(Continued on Page 488)

to help vanquish depression marked by "morning tiredness"

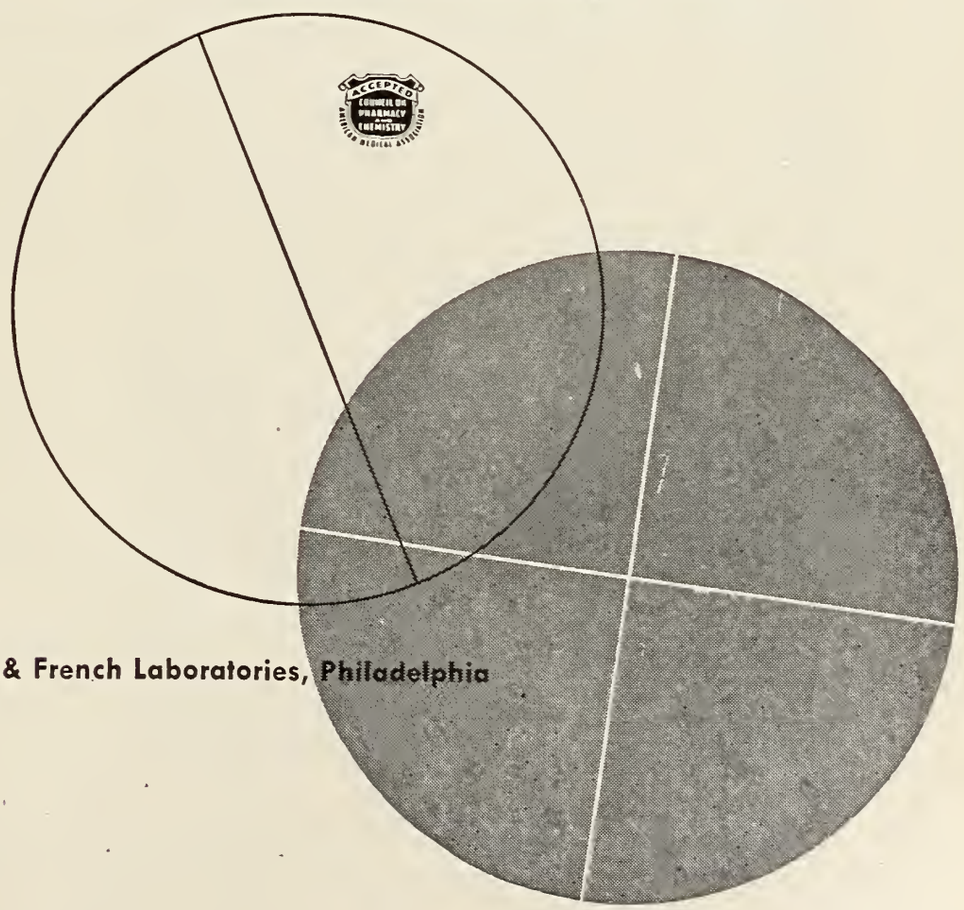
Many depressions are marked by morning tiredness, inertia, lassitude and retardation. 'Benzedrine' Sulfate, taken on awakening, frequently helps to lift the patient "over the hump" of the early hours.

Benzedrine Sulfate—where it shortens, eases, or even eliminates the patient's struggle with depression—may improve the tone of his entire day. While not always effective, Benzedrine Sulfate therapy certainly merits a fair clinical trial in depression marked by morning tiredness.

Tablets Capsules Elixir

Benzedrine* Sulfate

One of the fundamental drugs in medicine



Smith, Kline & French Laboratories, Philadelphia

*T.M.REG.U.S.PAT.OFF. FOR RACEMIC AMPHETAMINE SULFATE, S.K.F.

NATIONAL SCHOOL HEALTH SERVICES ACT OF 1947

(Continued from Page 486)

directed to develop demonstrations in each state in the interest of uniformity.

Dr. Reginald Atwater, Executive Secretary of the American Public Health Association, was the third witness, and also approved the original bill, but stated that he had not had sufficient opportunity of studying the amendments.

On the second day, the first witness was *Dr. James R. Miller,* of the AMA, who called the Committee's attention to the fact that neither in the original bill nor the amended bill is there any provision for consulting with the family of the child or with the family physician. He supported the principle of the bill that the best facilities for the prevention and diagnosis of disabling conditions in children should be undertaken, on the State level, and not from a national level, and that correction and treatment must be a family responsibility. He presented statistics from his experience in community work in Hartford, that showed that the families will do their share. He called attention to the AMA's ten-point program as proof of long-standing interest in the subject. Senator Smith developed the idea of the State's responsibility, by cross-examination, and stated that he had had considerable correspondence with State officials to the point that they are greatly concerned over the inroads to their executive functions by national agencies. Dr. Miller also called attention to the fact that, when differences of opinion as to the merits of State programs arise between the Federal Security Administrator and the State authorities, the bill provided that the Administrator's opinion should be final—even though provision is made for public hearings. He suggested that the provision in the Hospital Construction Act—that such differences of opinion can be taken to the Circuit Court for a decision—be incorporated in this bill. Senator Smith commented on this matter by stating that he had asked Mr. Ewing, on the previous day, as to whether his authority in the administration of the Act was superior and final to that of the State.

Dr. Vlado Getting, the Health Commissioner of Massachusetts, suggested that the bill as amended (which he stated he had insufficient time to study carefully) contain two separate ideas: (1) medical examination and services for children; and (2) physical education and instruction; and further suggested that separate bills be drafted. Senator Saltonstall, who was sitting with Senator Smith (no other members of the Committee were present at either hearing) stated that the introduction of the educational feature did not entirely meet with his approval, and that at any rate, he wanted considerable time to study the amended bill before he should be able to decide upon its merits.

Dr. John P. Hubbard, of the Academy of Pediatrics, and director of the study which the Academy has been making of the health conditions of school children, testified in favor of the bill and presented some statistics which are the result of their study.

Clyde A. Erwin, Superintendent of Schools in North Carolina, and Vice President of the School Officers Association, stated that, in his Association's opinion, the bill offered the wrong approach to the problem, and that health services to school children is a problem of the Education Department and not of the Health Department. He even advised against a joint administration.

At the close of the hearings, Senator Smith announced that further hearings may be held. Obviously, the merits of the bill are quite controversial and yet its backers, the PTA, do not seem particularly impressed by the defects and are likely to urge its enactment. Let us suggest, therefore, that each of you study the bill and discuss it with your Congressmen. If you do not have a copy, we will be glad to send it to you on request.

NEW DRUG, DEVELOPED SINCE WAR, ALLEVIATES MANY KINDS OF PAIN

A new drug, made available in this country after World War II, has been found effective in the alleviation of many kinds of pain, according to an article in the April 3 issue of *The Journal of the American Medical Association.*

The drug, which was given the non-proprietary name of methadon by the Council on Pharmacy and Chemistry of the American Medical Association, was originally prepared by German chemists and was known as drug 10820.

Writing in The Journal, Elizabeth B. Troxil, M.D., of the Department of Pharmacology of the University of Minnesota Medical School, says that in April 1946 clinical trials of the drug were instituted at the University of Minnesota Hospitals and that it was tried on 400 patients for relief of all types of pain.

Some of the conditions for which it was used to alleviate pain were: postsurgical, primary and metastatic cancer, arthritis, neuritis, headache, leg ulcer, anginal pain, and gastric and duodenal ulcers.

The drug was administered orally—in capsules, tablets, and elixir—and by hypodermic and intravenous injection.

"Onset of action," the article says, "was two minutes when given intravenously, within fifteen or twenty minutes when given hypodermically, or when given orally as the elixir, and thirty minutes when given orally in capsules or tablets.

"By all routes of administration it was found that the average duration of action was from three to four hours, with many of the patients obtaining relief for as long as eight to twelve hours."

One group of investigators found in experiments carried out on animals that the new drug had some of the characteristics of both morphine and merperidine. The effects on the nervous, circulatory and respiratory systems were similar to those of morphine.

Other investigators found that methadon was more potent than either morphine or merperidine.

Still another group observed the effects of methadon in former morphine addicts and found that the abstinence symptoms from morphine could be controlled

(Continued on Page 494)

The advice is always "SEE YOUR DOCTOR"

To an audience of over 23 million people, in LIFE and other national magazines, Parke, Davis & Co. presents the message shown below. This is the 211th advertisement in the campaign in behalf of the medical profession, published continuously since 1928.

A reproduction in full color will be sent on request. Write Parke, Davis & Company, Detroit 32, Mich.

Some things you should know about reducing your weight

No. 211 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



It is an accepted medical fact that excess weight can impair your health and efficiency, and possibly shorten your life.

One person's proper weight may be quite different from another's, however—even though their height and age are approximately the same. A large-boned, muscular person, for instance, should weigh considerably more than a small-boned person of the same height and age.

How much you should weigh is something to leave up to your doctor. Only your doctor can accurately judge whether your weight is within normal limits, or whether a loss or gain in weight is medically advisable.

If your doctor tells you that you weigh more than you should, it's just good sense to do something about it under his supervision. *To undertake a weight-reducing program without proper medical guidance is a foolish, and often dangerous, thing to do.*

It would be pleasant if there were some simple pill which would automatically and safely reduce your weight with no effort on your part. Unfortunately, *no such remedy exists.* So-called "reducing pills," taken without a physician's advice, are usually valueless and may be dangerous.

One type of pill, for instance, will cause you to lose weight—but only for a day or two! Its action is to remove water from body tissues, thus lowering your weight. But as soon as the water is replaced, the extra pounds are back again.

Another thing to beware of, in an effort to lose weight, is any sort of faddist diet.

A liquid diet may often be just as fattening as a normal one. A diet which concentrates on a particular food, and excludes most other foods, may deprive you of nutritive elements essential to the maintenance of good health.

SEE YOUR DOCTOR. Let him decide whether you should lose weight, how much you should lose, and how quickly. Let him tell you how you can do it without starving yourself, without risking your health. He can recommend a well-balanced diet. He can advise you about exercise. If he thinks medication will be helpful in your case, follow his instructions about dosage *exactly*. His advice is the only advice you can trust in matters that concern your health.

Makers of medicines prescribed by physicians **PARKE, DAVIS & CO.** *Research and Manufacturing Laboratories, Detroit 32, Mich.*

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PR in Practice

New Publication

Watch for your copy of *PR BYLINES*—a printed newsletter on activities of the MSMS Public Relations Committee. *PR BYLINES* reports all projects having definite public relations connotations.

The first issue of PR BYLINES has been sent out to the members of the MSMS, and the second issue is now in the process of compilation.

Medical Associates

R. H. Pino, M.D., Detroit, Chairman of the Commission on Health Care, developed the concept of Medical Associates in his address before the Michigan College Association at Ypsilanti on May 4. The purpose of his talk was to familiarize Michigan's educational leaders with the opportunities which are offered in this field.

Dr. Pino explained the survey of needs for Medical Associates which is being carried on by the Public Relations office of the MSMS, and illustrated his talk with many of the pictures which have been incorporated in the Medical Associates brochure.

The Medical Associates brochure is either in the printer's hands—or yours. You are invited to read this brochure closely and call it to the attention of your friends. Additional copies are available on request.

Selling the Community

Starting slowly, but rapidly gathering momentum is the Community Enrollment Plan of the Blue Cross. It makes friends for voluntary health insurance in every community in which the plan is attempted. It is probable that the Plan can be made available in your community, *if* you request it. Write R. L. Novy, M.D., President, Michigan Medical Service, Washington Blvd. Bldg., 234 State Street, Detroit.

Newspapers

Michigan newspapers are going more than half way in giving a good "press" to medicine. It is both sympathetic in nature and generous in quantity. Why not tell your local editor that you appreciate his help—and offer your co-operation?

New Man

Harold W. Corsette has been added to the Public Relations staff. Mr. Corsette is a recent graduate of Michigan State College in Journalism.

Rural Health

The second annual Michigan Rural Health Conference has been approved by the Executive Committee of The Council. A comprehensive report on the first Conference is being published with an accompanying review of the activities carrying out the recommendations of the Conference. It is surprising the great amount of progress which has been made since the Conference platform was adopted.

The brochure of the first Michigan Rural Health Conference has been printed, along with a mimeographed review of the progress of those activities called for by the Conference.

Features

A three column Rheumatic Fever news release with pictures sent out in mat form to all of the newspapers in Michigan has appeared in over 210 to date, also in a recent issue of *Michigan Farmer,* and a picture furnished by the MSMS appeared illustrating a rheumatic fever article in the *Country Gentleman.*

Three new Michigan radio stations have been added, making a total of twenty now carrying the "Tell Me Doctor" program. The new stations are WJRP Ishpeming, WBCM Bay City, and WTCM Traverse City.

* * *

The final contract with Michigan State College for the Michigan Health Survey has been signed, and the Sociology and Anthropology Department of the College has begun work on the project.

* * *

Nine scripts for the transcribed Sex Education program have been completed. The remaining six should be finished by the time you read this, and work begun on their production for the schools of Michigan.

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Protein in S-M-A is complete and adequate. It is present in the same proportion as in breast milk. Protein in S-M-A is *utilized for growth.*

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The S-M-A formula is well suited to modification, as the physician may wish, for special feeding problems.



Political Medicine

THE DOCTORS FIGHT

The British socialists have run up against a formidable rock in the path of nationalizing everything. That is the British medical profession, which has just voted 1 million 600 thousand dollars to fight the Labor government's campaign to force them into manning the state insured medical service, scheduled to be instituted July 5.

On February 18, when a vote was taken by the British Medical Association, 40,814 doctors rejected the scheme, as against 4,735 in favor. This amounted to a majority of 89 per cent, and all but three per cent of the group went on record as refusing to accept service under the national health act.

Aneurin Bevan, minister of health, was left in the position of trying to put the nationalization plan into operation with but 3,560 general practitioners and 971 consultants and specialists to serve 47 million people. The act obliges both employers and employes to make compulsory weekly contributions for service, and every man, woman, and child in Britain would be eligible for attention.

Mr. Bevan has proceeded on the theory that the doctors can be dragooned into service despite their opposition by economic pressure. The "independence" fund voted by the B.M.A. is the profession's answer. The doctors said that the health act is inacceptable as long as it fails to "maintain the integrity of medicine and prevent doctors being turned into state servants." Lord Horder, personal physician of the King, denounced Bevan for "unscrupulousness."

For the first time in their nationalization schemes the socialists are not dealing with the common labor of mass industries, but are confronted by individualists with a high degree of specialized training and skill. Laborite politicians and union bosses alike are incapable of handing down orders and getting obedience.

If the fight against regimentation and tyranny by the all powerful centralized state is to be won in Britain, it will be because there are still Englishmen who, like the doctors, have dignity and pride in their attainments as individuals, and who refuse to be reduced to ciphers on the state pay roll. By holding fast, the doctors can hope to reverse the tide of socialism and save Britain.—Editorial, *Chicago Tribune,* March 23, 1948.

SOCIALIZED MEDICINE IN GREAT BRITAIN

Leslie Hartley, in a letter to the *British Medical Journal* (Feb. 28, page 407), gives the following reasons why most of the doctors in Britain, nine to one, are voting against Socialized Medicine.

The General Practitioner.—(1) The general practitioner is asked to sign a contract for a 24-hour day seven days a week and 365 days a year with no provision for holidays or for illness. This is not the comprehensive health service which the supporters of the Act have put before the public, where the doctor was to have plenty of leisure, time for postgraduate study, and proper holidays.

(2) No provision is made for any secretarial assistance for the doctor, but it must all be done by wife or his domestic servant, if he has one. The terms of remuneration do not allow for the payment of a secretary, and if they did it would be necessary for the doctor to have two secretaries, as I am sure no secretary could be asked to work 24 hours a day, particularly in view of the large masses of forms and certificates which will be added to the doctor's burden. The modern domestic servant is not usually capable of taking a correct telephone message, and so it is the doctor's wife who will suffer, and I am afraid the only remedy is polygamy.

(3) The remuneration is quite inadequate. A well-qualified practitioner in a good-class area can only earn £1,000 a year gross, as it is impossible with this type of patient living in a scattered area to look after more than 1,000 patients properly. In a poor-class area a doctor may be able to earn £3,000 or even £4,000 a year, provided always that he does not examine his patients.

The Specialist.—(1) The public have been told that under the new service they will all get attention in well-equipped hospitals. So far from any attempt to build and equip any new hospitals, the Minister has refused to allow many existing hospitals to make extensions and improvements which were held up owing to the war and which they were quite prepared to do out of their own funds.

(2) No attempt has been made to increase the number of nurses, but the training of new nurses has, on the other hand, been curtailed by the Minister's condemnation of the smaller hospitals.

(3) It is impossible to discuss the question of remuneration, as this is not known until six months after the Service starts, and this is bound to deter even the most trusting.

(4) There is no compensation for the goodwill of specialists' practices. While the goodwill of practices in the Harley Street area may not be a salable asset, it is on the other hand a very valuable asset in the country, and many provincial specialists have paid large sums for their present practices.

MONEY AND FREEDOM

Reports from all parts of the country suggest that an overwhelming majority of doctors are radically opposed to the National Health Service Act in its present form. Medical men are convinced that this Act is the first and substantial step towards a whole-time State Medical Service. Even those who might be inclined to "give it a chance" see the grave risks of saying Yes. This Act is Mr. Bevan's revolution. Once the profession crosses the Rubicon there will be no retreat. Mr. Bevan will have the power by Regulation to make men whole-time servants of the State. Once in his Service we shall be power-

(Continued on Page 494)



But... WET DUST CANNOT FLY!

Did you ever notice the fine layer of dust that settles on tables, chairs, and other polished furniture after you finish vacuuming? That is because dust has been taken out of the carpets and upholstered furniture and blown into the air through a porous bag.

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MONEY AND FREEDOM

(Continued from Page 492)

less to do anything more than haggle over terms and conditions.

It is important to stress again that the National Health Service Act is not an insurance scheme, and therefore is something radically different from the National Health Insurance Acts under which at present a large proportion of the population of this country is receiving medical care.

Mr. Bevan thinks that for the State to own everything is good and that for the individual to own anything is bad—a not unusual thesis among the apostles of collectivism.

But one illusion still seems to persist, and that is that with the introduction of this Act medical men will work shorter hours on fixed rotas, and have longer and better holidays. Mr. Bevan cannot create more doctors, cannot build more hospitals, cannot build more health centres, cannot build more houses. He refers in his circular of January 14 on Health Centres to "the sheer practical impossibility of a new building programme."—Editorial, *British Medical Journal,* Jan. 24, 1948.

BRITAIN OFFERS DOCTORS VOICE IN MEDICAL ACT

London—Minister of Health Aneurin Bevan made a major concession to the British medical profession.

He did it in an effort to induce the doctors to accept the universal medical service scheme scheduled in Britain next July 5.

Bevan informed the House of Commons that the Cabinet proposed to offer amendments to make it impossible for the Government to institute a full-time, state-salaried medical service without express legislation.

His statement was considered so important that the executive committee of the British Medical Association's council called a special meeting Thursday to consider it.

The committee will discuss whether to reopen negotiations with Bevan on changes in the Health Service Act, to make it acceptable to the majority of British doctors.

The physicians have voted overwhelmingly against accepting service under the act as it now stands.—*New York Times* (Foreign Service), April 8, 1948.

AS WE SEE IT

What Britain's medical profession thinks of the Labor Government's plan to extend Socialism into the field of public health by nationalizing medical service, was shown by a poll of the doctors.

Eighty-six per cent of them voted against participating in the plan. This means there is little likelihood that it can be successfully put into operation by July 5 as scheduled.

We doubt if the doctors' determination not to become socialized was prompted primarily by the question of fees alone.

Better than anyone else, they knew that socialized medicine, becoming part of a huge governmental bureaucracy, would mean only the deterioration of professional standards and subsequent harm to the general public.—Editorial, *Detroit Free Press,* Feb. 20, 1948.

NEW DRUGS DEVELOPED SINCE WAR

(Continued from Page 488)

with methadon. When methadon was withdrawn abruptly after prolonged administration, the symptoms were so mild that treatment was not necessary.

In the study carried out on the 400 patients, it was found that 81 per cent had adequate or complete relief of pain, and "this figure would be increased to 86 per cent if the group of patients who received methadon for labor pains were excluded, since the drug has proved to be ineffective in this type of pain."

Dr. Troxil says that it was possible to use methadon to relieve muscular spasm and pain in patients with bulbar and spinal poliomyelitis and that it also was used effectively to relieve headaches due to brain tumor, head injury and brain abscess.

Approximately twenty patients receiving methadon for two or three months had no withdrawal symptoms on abrupt discontinuation of treatment. Three patients were given the drug for one year and were able to stop treatment abruptly without ill effects.

THE HILLSDALE PLAN

(Continued from Page 478)

taken for such examinations when the patient comes for some other purpose thus saving time for both patient and physician. There is no disturbance of physician-patient relationship and, with the discovery of many other abnormal conditions besides cancer, corrective measures can be instituted without delay. The expense of equipping and maintaining a cancer detection center also can be avoided.

The "Hillsdale Plan"—possibly with modifications to meet local needs—can be adopted by medical groups in practically any area. By such a plan every physician's office becomes a cancer detection center, an objective that must be attained in order to render the greatest possible service of which the medical profession is capable to the control of cancer.

How big a start did your last CANCER case get on you, and whose fault was it?

. . .

Time, tide AND CANCER wait for no man.

. . .

Consider CANCER at ANY age.

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Medicine and the Future

By Lowell S. Goin, M.D.

Los Angeles, California

SOMEWHERE in sacred literature there is a brief word-picture of the restless and uneasy citizen, unable to sleep, pacing the dark streets of the walled city and calling to the watchman on the walls, "Watchman, what of the night?" and getting the reassuring answer, "The morning cometh." And we, looking into the dim future and calling anxiously to our watchman, seem to hear the same comforting answer. But perhaps the watchman, gazing toward the eastern sky, dazzled by the first flush of the rising sun of knowledge ushering in the dawn of the scientific era in medicine, fails to hear the ominous rumblings on the left or to note the dark shadows drawing near.

If I were a preacher, I should take for my text "A voice crying in the wilderness," and I should remind you how very few listened to that voice. If I were an orator, I should quote the fiery periods of William Pitt as he warned the British Parliament that a continuation of its policies would result in the loss of the American Colonies, and I should not need to remind you that they would not listen. Since I am neither orator nor preacher, but only a physician who is becoming alarmed over what he believes to be a menace overhanging our profession, I must content myself with the statement of my thesis and the presentation of factual data to support it. Simply put, it is this: During the past twenty years there have been rapid and extensive changes in the traditional function of the hospital in its relation to the practice of medicine, and the profession of medicine is now entering a critical period in which it will be decided whether the fields of diagnostic, therapeutic and preventive medicine shall be dominated by physicians or hospitals. Much more recently the medical school has entered the practice of medicine, in competition with its graduates, adding new confusion to the already complex problem of how medical care shall be given and by whom.

As every treatise on semantics points out, much useless and unprofitable disputation occurs because those who dispute are attributing different meanings to the same words. Let me make it clear, then, that the word "hospital" does not signify, in this discussion, the familiar and friendly place where the physician carries on part of his practice—an institution that probably would not harm him if it could, and in all likelihood could not harm him much if it would. On the contrary, the word "hospital," as I am using it, means that impersonal and abstract thing, the hospital world, the association of hospitals, the microcosm of the planning commissions.

Whether deliberately or not, current tendencies on the part of hospitals find their keynote in the first recommendation made by the Committee on the Costs of Medical Care. In 1929 the committee recommended that medical care be furnished by groups, organized around a hospital. Thus the hospital becomes the dominant factor in the delivery of medical services. The importance of the traditional family doctor as the prime figure in a program of adequate medical care is obscured in a trend toward institutionalized medicine with the hospital as the central figure. Is this an exaggeration? Let me quote an excerpt from an address recently delivered by an executive of the American Cancer Society: "The care of

Read at the twenty-first annual meeting of the National Conference on Medical Service, Chicago, Illinois, February 8, 1948.

the cancer patient naturally revolves around the hospital. There he had his first treatment; there he will return for subsequent care." There was no ulterior motive underlying this, and the speaker had no intention of uttering any radical or controversial statement. He was simply stating, as a matter of fact, something that seemed to him to be indisputable and quite natural.

Steps toward the goal of institutionalized medicine were taken when hospitals began the operation of pay clinics and out-patient departments in competition with the private physician's office, abandoning the old concept that out-patient services and part-pay clinics should be maintained only in teaching institutions where patients could be used for clinical material. Further steps were taken when the "middle rate" plan was adopted by a number of hospitals, in which patients were admitted on an adjusted fee basis, including not only the hospital bill but the bill for medical care as well. Other hospitals instituted "flat rate" or "all inclusive" plans, under which a patient could be admitted to the hospital for diagnostic services and pay a flat fee covering the complete cost for medical services and hospital facilities. Still further and more radical steps were taken when hospitals began the sales of insurance plans which offered as benefits not only the use of the physical facilities of the hospital but the services of medical specialists as well.

We are living in an era of great social change, an era comparable, perhaps, to the end of the feudal period and the inception of the modern industrial civilization. Powerful forces are urging upon us the socialization of society, and it must be obvious to every reasonably literate person that the socialization of medicine is one of the first steps toward the achievement of that objective. What is not so obvious is that the expanding activities of Blue Cross plans, some of our large teaching hospitals and medical schools may well form the spearhead of the attack which has for its goal the substitution of socialization for free private enterprise. The very essence of socialism is the subjugation of the individual, while a fundamental tenet of our system of democracy is the importance of the individual. It is not by accident that we say "the man in the street" rather than "the men in the street." Every individual is hedged around with rights, protecting his peculiar person and his peculiar property. Since society is only a very large group, the social planner has seen that although it is difficult to persuade men to hand over their personal rights and freedom to the state, it will be less difficult to get them to surrender these to smaller groups over which they appear to have some control. This done, and the smaller group having assumed the privileges once belonging to the individual, the final step of transferring them to the larger group called society or the state becomes much easier.

I do not mean to attack or belittle the Blue Cross plans. On the contrary, I regard them with admiration, and I believe that they serve a very useful purpose, especially where they operate in conjunction with voluntary medical care plans. The trouble with them is that they appear to be unwilling simply to provide hospital care; they insist on turning group hospitalization into group medical care, with the medical care being furnished by the hospitals. Here begins the first step in the subjugation of the individual and his disappearance into the comparatively small group.

Of course it will not do simply to make this flat statement and pass on. Perhaps the statement is a purely emotional one, not based on observable facts. Actually, it isn't very difficult to offer some documentation. Clinical pathology, anesthesiology and radiology are now claimed as hospital services. The argument for this claim reminds me somewhat of that attributed to the Rev. Mr. Still when his brother announced the discovery of osteopathy: "John, you may be right, and Praise God, there's money in it!" But if hospitals may include these medical services, what will prevent them from including cystoscopy, tonsillectomy and normal confinements? The hospital administrator replies that the hospital hasn't the least desire to practice medicine, but at the same time he issues such documents as:

"It's a Fact"

By Melvin L. Sutley, Supt., Delaware County Hospital, Drexel Hill, Pennsylvania

"Both antenatal and postnatal clinics are operated by the modern hospital.

"Everything known to science, including x-ray machines and other costly equipment, is called into play for the benefit of both mother and child. Thus an expectant mother, who places herself early under the protection of a hospital's maternity department can avail herself of medical observation and care for more than a year.

"In the antenatal clinic, the prospective mother's general health is improved. Her strength is 'built up.' If obscure symptoms exist, they can be treated and corrected, before the infant is born. . . .

"The postnatal clinic is operated for the benefit of both mother and child. They may make visits every month for an entire year, receiving advice as to the correct diets based on the baby's weight and health, and correction of any troubles which may develop.

"During this period there may be occasions when x-ray may be required again, for either mother or infant. And the treatment may involve the use of much other equipment, available now in the hospital, undreamed of even twenty-five years ago. . . .

"If he's a clinic baby, the chances are that both he and his mother are healthy and happy, with all the health advantages that science can bestow."

You notice, I suppose, the credit given and the reference made to the physicians who see these cases?

The official publication of the American Hospital Association has stated flatly (*Hospitals,* p. 73, May, 1937): "Diagnosis, treatment, and the care of the ambulatory sick become increasingly the functions of the hospital as the hospital develops into the center of community health activities." Again, (*Hospitals,* p. 67, September, 1937) we read, "The patient, whatever his economic status, is entitled to receive the necessary service of the clinician, the surgeon, the pathologist, the radiologist, the nurse and the lay people who attend him. *All these services are a part of the hospital. . . .*" On page 63 of the same number, the diagnostic skill of the modern hospital is praised in these words: "The hospital is an indispensable public utility because of the wide variety of diagnosis and treatment it offers." Says the Board of Trustees of the AHA, "Provision of medical service in hospitals is part of the responsibility of hospitals," and W. P. Slover, in the official journal of the AHA, advises hospitals to increase their revenue by educating the public to more regular use of the laboratory, the x-ray and diagnostic services for systematic check-ups on their health.

There is grave doubt that such hospital activities are lawful, and it is quite likely that hospitals and medical schools that offer medical services to the public are violating the laws which forbid corporations to practice the learned professions. The journal of the AHA has stated editorially that "the laws regulating the practice of medicine by corporations do not apply and were never intended to apply to hospitals." Michael Davis, in a paper entitled "Do Corporations Practice Medicine" says, "the hospital corporation, if it is a corporation, is not practicing medicine in a legal sense." The various supreme courts, however, seem to be in something less than complete agreement with these theses, and have regularly ruled that corporations cannot evade the laws against the corporate practice of medicine by hiring licensed physicians. A typical decision is that by the Supreme Court of Massachusetts in an action entitled McMurdo versus Getter (10 NE 2nd 139), in which the Court said: "The rule is generally recognized that a licensed practitioner of a profession may not lawfully practice his profession among the public as the servant of an unlicensed person or corporation; and that, if he does so, the unlicensed person or corporation employing him is guilty of practicing that profession without a license. . . . In the absence of statutory modifications in favor of hospitals or others, the same rule . . . applies."

The growing tendency of medical schools to engage in the practice of medicine is a disturbing phenomenon. It is quite true that their tuition fees and their endowments no longer suffice to defray the expense of educating the medical student. Nevertheless, their legal and moral right to enter the practice of medicine seems extremely doubtful. It must be clear that if the Supreme Court decision just quoted is to be regarded as law (and such decisions *are* law unless they are modified by legislation), the medical school has no more right to practice medicine than does a hospital. The morality of a medical school competing with its own graduates is a little shaky, but of much greater significance is the effect of such competition on the future of medical practice and the public health. In the past, thousands of young men have been led to enter the study of medicine by reason of the affection and admiration which they felt for the physician who cared for their families, and by observation of the obvious fact that the doctor lived a bit better than the laborer, the salesman, and the clerk in a store. But think for a moment: who can blame the prospective patient who reasons that he would be foolish to see Dr. Brown when he can as well go to the medical school and have the services of the great men who are the professors. The patient, of course, is quite unaware that very rarely, indeed will he see the professor, and that there is no particular reason to believe that a given doctor will

administer any better medical care in a medical school clinic than he would give in his office. As the family physician thus loses prestige and income, the young men who formerly emulated him will be less and less inclined to do so, the practice of medicine will become less and less attractive, and fewer and fewer young men will enter it. As the amount of tuition received declines, the problem of the medical school will become more acute, and its operation by a paternal government will at last be the only possible solution to the problem. "Whom the gods would destroy, they first make mad," said the ancients.

But, you will say, the American Medical Association will surely say something about such things as these. It has spoken, and very definitely. In the code of ethics we read, "It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him." In 1936 the Judicial Council of the American Medical Association said: "It would seem that in this time of extensive changes in hospital economics the point had arrived at which further marriages between hospitals and staff physicians that made the doctor of medicine the servant of the hospital should be stopped and a series of attempts at divorce among marriages that have already taken place should be instituted. Our accepted ethical principles are adequate at the present time and hospitals would be of invaluable assistance. It is not an impossible task but will need a militant local and national ethical spirit behind it and a frowning on those individuals in the profession who on personal grounds do not object to the gradual subjugation of the medical profession in the growth of hospital domination.

In 1937 the House of Delegates of the American Medical Association defined hospital care as consisting of room, board, ordinary nursing care and routine drugs. Do the hospitals bow to this supreme authority in American medicine? Not at all; they simply inquire editorially in their official journal, "Is it the prerogative of the medical profession to decide on hospital policies—? Should the trustees of hospitals included in reputable nonprofit group hospitalization plans be told what they must and must not do?" If I have not made out a case in support of my thesis, the fault is my lack of skill. I feel very sincerely that the menace of hospital domination is a real one, likely to remove from the hands of its natural trustee, the physician, the priceless heritage of medicine. I think that you will agree the answers to the rhetorical questions of the hospital journal should be: "Yes, it *is* the prerogative of the medical profession to decide on hospital policies when those policies concern the field of medical care," and "Yes, the trustees of hospitals included in reputable nonprofit group hospitalization insurance plans *should* be told what they must and must not do when the subject under discussion is the dispensing of medical services." The medical profession has neither the right nor the wish to dictate hospital policies to hospitals, but it cannot and must not permit the forcible translation of the practice of medicine into hospital service. Nor is the invasion of the field of the practice of medicine by the medical school any more tolerable, and its justification is equally difficult.

I ask you to acquit me of any ulterior or selfish motive. I will neither gain nor lose more than any of you if these things do or do not come to pass, although any person who takes a decided attitude in a controversial matter is certain to lose something, in that he surely will incur new enmity and increase the disesteem in which he may already be held in some circles. But I have a simple, perhaps even childish, idea that truth and the right are worth striving for, and I cling to the simple belief of old: "If God be with us, who may be against us?"

MSMS

LESSON IN ADDITION

Rep. Woodruff (R., Mich.), who has been in Congress longer than any other Michigan member, adds up all the money the United States has spent and promised to spend in aid to foreign nations and gets a two-war, 30-year total of $104,000,000,000.

"There is something so abnormal, so self-annihilating, about a program that calls upon one country to take care of twenty others that I cannot believe such a program originated in the United States," he says.

* * *

In the fight for a cancer cure, it is not the age of the patient that counts, it's the age of the cancer in that patient.

The Part of the General Practitioner in Management of Vesical Neck Obstruction

By Frederic E. B. Foley, M.D.

Saint Paul, Minnesota



MOST CASES of vesical neck obstruction come to the urologist through the hands of the general practitioner. Many of them come because the general practitioner knows exactly what is wrong and what should be done. That's as it should be. Other cases come merely because there are urinary symptoms and the general practitioner doesn't know what is wrong or what should be done. That's not as it should be. He should know what is wrong, and he doesn't need a cystoscope to find out. Other patients in need of surgical interference remain unduly long in the hands of the general practitioner, taking urinary tract antiseptics and prostatic massages to no good purpose. That, too, is not as it should be. And finally, some few cases never do get to the urologist. Either purposeless palliation is pursued to an unnecessary fatal outcome or surgical management is accorded by incompetent hands. That certainly is not as it should be.

I state these things as one who for twenty years has had a remarkably happy relationship with a host of general practitioner colleagues throughout the Northwest—men who have given me a large and interesting referred practice in my special field. That is not to say that these men in general practice and I have jointly managed our task to the best advantage of our patients. I am only too well aware of my own deficiency in the matter—but my shortcomings and my part in the job are not my subject. I have also come to see the shortcomings of the general practitioner and to know that his part in our joint enterprise can be improved. That is my subject.

In the management of vesical neck obstruction, the proper part of the general practitioner lies in diagnosis, in preoperative management, in directing the patient to competent surgery at the proper time, and in postoperative care.

For the surgical part of management, many of these patients must go considerable distance from their homes to hospitals in large centers. Much time and expense can be avoided if the patient is kept ambulatory under the care of his family physician while a definite diagnosis is made and during the period of preoperative treatment and for much of the postoperative care. All of these—diagnosis, preoperative treatment and much of the postoperative care—can and should be done by the patient's family physician, to the end of avoiding needless loss of time and unnecessary hospital expense.

When a patient presents himself with urinary symptoms, the general practitioner can and should promptly find the answers to the following questions:

1. Is the trouble due to vesical neck obstruction?
2. What type of vesical neck obstruction is present?
3. Is surgical treatment required at once?
4. May palliative treatment be employed safely with postponement of operation?
5. Is the patient ready for immediate operation, or will he be made a better surgical risk by preoperative treatment directed by the general practitioner?

Let us take these questions in order.

Is the Trouble Due to Vesical Neck Obstruction?

In considering this question, it is a great mistake and will lead to blunders to think that benign prostatic hypertrophy and prostatic carcinoma in the elderly man are the only causes of vesical neck obstruction. There are other causes, less frequent it is true, but for the patient who has such obstruction they are more important than benign hypertrophy or carcinoma. And one should not lose sight of the fact that vesical neck obstruction does occur in young individuals, that it is often present without palpable enlargement of the prostate, and that it may occur in women.

From the history alone, the physician can usually come close to knowing whether or not there is obstruction. The typical symptoms in order of onset are:

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1. Hesitancy in starting the stream. At first this may affect only the first urination in the morning. Later it is noted at the urinations during the night, and still later it is always present.
2. Nocturia. This may be the only symptom.
3. Increased daytime frequency.
4. Urgency.
5. Decrease in the size and force of the stream.
6. Interrupted urination.
7. The sensation of incomplete emptying.
8. Complete retention of urine.

The appearance of these symptoms one after another—some or all of them—and final presence of most of them means only one thing: vesical neck obstruction.

The impression as to the presence or absence of vesical neck obstruction gained from the history will be verified at once by a very simple and cursory kind of physical examination and in nine cases out of ten without the use of the cysto-urethroscope.

The patient should be examined at a time when he has a real desire to urinate.

The act of urination in the standing position is observed. The patient is instructed to empty the bladder completely. If there is obstruction at the neck of the bladder there is usually some degree of hesitancy in starting the stream. The size and force of the stream are noted. Even with well developed obstruction, the first part of the stream, when the bladder has tone because of its filled condition, may be of good force. An abnormally prolonged terminal decrease in force is significant. After the patient has voided to empty, a catheter is immediately passed. This must be done with the patient in the erect position. The residual urine contained in a very atonic bladder will not evacuate through a catheter with the patient in the recumbent position. For the same reason, residual determinations should follow voiding to empty with the patient in the erect position. The presence of residual urine is an important finding. Residual urine in excess of 30 c.c. is positive proof of vesical neck obstruction. However, absence of residual urine by no means rules out obstruction. If the bladder has reacted to obstruction by concentric hypertrophy, the powerful trigone may be capable of pulling open the obstructed vesical neck, and the well-compensated detrusor may force complete evacuation.

When a history containing significant symptoms of obstruction is combined with the presence of residual urine, one may say with confidence that there is vesical neck obstruction. This becomes a certainty when the obstructive symptoms and residual urine are combined with physical signs of the obstructing lesion.

The physical signs of the obstructing lesion contain the answer to the second question:

What Type of Vesical Neck Obstruction Is Present?

The cause of vesical neck obstruction to be borne in mind are, in order of frequency.

1. Benign prostatic hypertrophy.
2. Carcinoma of the prostate.
3. Prostatic bar.
4. Contracture of the vesical neck.
5. Inflammatory swelling of the vesical neck—acute prostatitis in men, acute urethritis in women.
6. Disturbances of innervation, the result of organic central nervous system disease, or functional disturbance as in postoperative retention.

This is not a very long list to be kept in mind. If the physiologic-pathologic approach is employed in taking the history and examining the patient very promptly, the condition present will fall under one of these designations.

Much is learned from the rectal examination in men and vaginal touch in women. Obstructions due to acute inflammatory change produce a boggy swelling of the prostate and tenderness to pressure on the gland. In women there is tenderness to pressure against the urethra and bladder neck. With post-inflammatory vesical neck contracture in women, the urethra when palpated against the pubic arch is much thickened and infiltrated. Post-inflammatory vesical neck contraction in men is usually associated with a small, somewhat irregular prostate which lacks the normal resiliance and is well described as "gristly." "Prostatism without a prostate," the old urologists called it.

Benign enlargement of the prostate may be almost entirely intravesical and give little or no enlargement palpable by rectal examination. In most cases, however, some degree of enlargement is apparent by rectal examination. The gland is smooth, usually firm, but resiliant. The globular lateral lobes form a sulcus on each side with the pubic ramus, and between the two lobes is a

well-defined median furrow covered by the uninvolved posterior lamina or lobe. The attachments are elastic, and the gland is very slightly moveable.

These characteristics on rectal examination sharply distinguish benign prostatic hypertrophy from carcinoma and make of the rectal examination the most valuable item we have in differentiation of the two conditions.

The typical carcinomatous gland is stony hard. The surface is irregular or even nodular. Distinct lateral lobes are not distinguishable, and the median furrow between them is obliterated. The sulci between the gland and the pubic rami are filled out, and obvious growth in these directions may be found. Fixation is so firm that no movement can be detected. The differential diagnosis between a carcinomatous gland and benign enlargement in which infection and cicatrization have occurred may be difficult.

From the history and physical examination thus far, and keeping in minnd the changes characteristic of the different obstructing lesions, one can usually say in general that there is vesical neck obstruction and say in particular that the obstruction is due to benign prostatic hypertrophy or to carcinoma of the prostate or to an acute inflammatory process—acute prostatitis or prostatic abscess in men, or acute urethritis and cystitis of the vesical neck in women.

When the physical changes characteristic of these conditions are absent, the remaining possibilities are post-inflammatory contracture of the vesical neck or disturbed innervation, which may occur in either men or women.

The first steps in the further differentiation should be careful reinquiry into the history and a cursory kind of neurologic examination.

A history of gonorrhea, or more important, postgonorrheal prostatis with persisting "morning drop," perineal discomfort, et cetera, is almost regularly obtained in cases of bladder neck contracture in men. In women the similar condition has usually been preceded by oft repeated attacks of "cystitis" which actually have been exacerbations of urethritis.

If the condition present won't fall into any of the mentioned forms of pathologic tissue change affecting the bladder neck, then disturbed innervation is the only remaining explanation.

A history of neurologic disturbances in general should always be looked for. Further inquiry may elicit a history of chancre and the later manifestation of tabes, such as ataxia and other symptoms of the disease. Or there may be a complaint of paresthesias over the saddle area or other neurologic disturbances to indicate other forms of central nervous disease. Any of these suggest the possibility of disturbed bladder innervation.

The cursory neurologic examination is extremely simple and embraces only pupillary reflexes, station and equilibrium tests, knee kicks, plantar reflex and sensation over the saddle area.

The presence of any significant neurologic signs disclosed by this examination suggest the possibility of disturbed innervation of the bladder and urethral sphincters as cause of the obstructive symptoms and residual urine. A neurologic consultant may give valuable aid in such cases. The possibility of symptoms being due to neurologic disease must be borne in mind constantly—even in cases where anatomic change in the vesical neck seems obviously to be responsible.

Finally in a very small number of cases it may not be possible from the history and ordinary methods of examination to say with confidence what causes the obstruction. In these few cases one must resort to the cysto-urethroscope.

Is Surgical Treatment Required at Once?

The answer to this is simple. It is determined by the grade of obstruction and severity of symptoms. The degree to which retention has impaired renal function and the general physical condition do not necessarily have bearing on the question of immediate operation, except to contraindicate it in many cases.

Obviously, the individual with complete retention of urine and in sufficiently good general physical condition for immediate operation should have the obstruction surgically relieved with as little delay as possible.

Likewise, the individual with severely distressing symptoms who is instantly a good surgical risk should be afforded the relief of surgical removal of the obstruction without delay.

A very large residual urine in the presence of sufficiently good physical condition to permit operation at once, or in the immediate future, is in a general way indication for such management. Postponement of operation in such cases usually leads to further impairment of renal function and deterioration of the general physical condition.

These convert a good risk into a poor risk. However, if the patient's family and business matters or other surrounding circumstances demand a little delay, this may appear appropriate. Such phases of the problem provide good exercise of the intimate relationship usually existing with the general practitioner or family physician. During the period of delay the patient should be under rather careful observation. It even may be permissible or advisable to have his report once or twice a day for catheterization. or to let him wear a self-retaining bag catheter through which the bladder is completely emptied several times during the twenty-four hours. During the period of postponed operation, these measures will avoid progressive damage, provided repeated over-distention of the bladder are avoided. They should be accompanied by the administration of one of the sulfonamide drugs to control the inevitable infection of an indwelling catheter or interval catheterization.

Very rarely, profuse bleeding from a very much enlarged and greatly engorged benign hypertrophy is an indication for immediate surgical interference. Contrary to popular belief, hematuria is much more suggestive of benign hypertrophy than of carcinoma.

May Palliative Treatment Be Employed Safely and Operation Postponed?

The patient is entitled to an honest answer to this question. I am sure he always gets it. But even an honest answer may be a prejudiced answer. In respect to this matter, I believe the prejudice of a general practitioner is fairer to the patient than the prejudice of the urologist.

The individual with only a small residual urine and not very troublesome symptoms, even though he has outspoken vesical neck obstruction, may safely postpone operation—sometimes indefinitely.

It may seem fairly certain that eventually operation will be required. In view of that, the urologist usually feels that the sensible thing is to change the operation from a prospect to a memory and at the same time give relief of the trifling symptoms. But after all, it is the patient's problem. If he prefers to put up with his not too distressing obstructive symptoms, have massages from time to time when the bladder irritation is increased, take sulfonamides off and on for control of infection, and co-operate in the other details of management, it is his own affair. The family physician, familiar with the patient's nervous make-up and factors in his domestic and business life which incline him to postponement, is much better qualified than the stranger urologist to help in this decision. In his palliative and expectant management of the situation, the general practitioner should bear in mind that obstructive lesions are usually progressive. Accordingly, frequent determinations of residual urine should be made. If residual increases to substantial proportions or the obstructive symptoms are not well controlled, and there are disturbances of sleep and inroads on the general physical condition, palliation should be abandoned in favor of surgical relief.

Is the Patient Ready For Immediate Operation, or Will He Be Made a Better Surgical Risk by Preoperative Treatment Directed by the General Practitioner?

The answer to this question lies in careful appraisal of the general physical condition with respect to cardiovascular system and other items apart from the urinary tract, and in appraisal of the degree of renal function impairment which has resulted from the obstruction.

It is eminently appropriate that the general practitioner should make these appraisals, arrive at a decision from them and carry out the needed preoperative treatment if this is indicated.

Many of these patients in need of preoperative treatment, whether it be for impaired general physical conditions, the result of cardiovascular trouble or other constitutional disease, or because of the inroads of urinary obstruction on renal function with nitrogen retention, do much better at home under the care of their familiar family physician than in a hospital under the care of the stranger specialist and his consultants.

It is not for me in my narrow specialty to suggest what should be done for hypertension, cardiac decompensation, other forms of cardiovascular disease, diabetes and other constitutional illnesses. I always depend upon consultants for this management. They know better than I how to deal with these conditions and improve the condition of the patient impaired by them.

The impaired physical condition and poor surgical risk which indicate postponement of operation and require preoperative treatment are often solely the result of renal function impairment. They are indicated by the typical clinical fea-

tures of uremia and verified by blood chemistry determinations. Urologists have always felt that the management of this condition and its correction is their special province. We do pretty well with it, but there is no reason why the family physician who will devote himself to the problem cannot handle it just as well. In this way, long periods of hospitalization and much expense can be avoided.

The first essential in the management of renal impairment resulting from vesical neck obstruction is drainage. In the vast majority of cases this can be provided by either interval catheterization or constant drainage by an indwelling catheter. Only rarely is drainage by suprapubic cystostomy required because of difficult catheterization or intolerance to the indwelling catheter.

With long-standing obstruction and impairment of renal function there always is a very marked decrease in the specific gravity of the urine. Determinations of specific gravity may be made from day to day. With the patient on a constant fluid intake, improving renal function will be indicated by a rising specific gravity.

Functional improvement can be measured more accurately by sending to a laboratory from time to time samples of blood for determination of the degree of nitrogen retention. For this, only the blood urea nitrogen need be reported. Changes in this value will indicate accurately changes in the renal function. Other indicators of improved renal function are increasing appetite, gain of weight, increasing alertness and interest in life, improvement of the usually present anemia, as indicated by color of mucus membranes, and improvement in the patients's condition in general.

If interval catheterization is employed, the catheterizations should be done frequently enough to avoid any discomfort from bladder filling, and at all events so frequently that not more than 400 c.c. of urine are found in the bladder. The frequency of catheterization must be proportioned to the fluid intake, or more exactly, to the urine output.

The Foley self-retaining bag catheter has eliminated practically all of the troublesome features that formerly attended constant drainage with a catheter held in place with adhesive tape. Some of my general practitioner friends tell me I should be cannonized for the night calls I've saved them during our Minnesota winters. These self-retaining bag catheters require no external fixation by adhesive tape or otherwise, can be kept in place for weeks at a time and require no adjustment or attention of any sort. In the majority of cases such a catheter is well tolerated and makes a much more satisfactory and less troublesome method of drainage than interval catheterization. When the patient is in bed or in a chair, the catheter may be connected to a drainage bottle. However, the catheter may be clamped off and permit the patient to be up and about with considerable resumption of activity. At intervals the catheter is opened to empty the bladder.

In cases of very long-standing obstruction accompanied by large residual urine, the degree of renal function impairment may be severe and recovery of function very slow. Several weeks or even months may be required for the maximal recovery of function possible. The management requires no specialized urologic talent. Preoperative treatment of this sort does not require confining the patient to a hospital or placing him under the care of anyone but his own family physician.

The preoperative treatment just outlined may be beset by complications. The urethra may become intolerant to either interval catheterization or an indwelling catheter. In this event, suprapubic cystostomy for drainage will be necessary. Severe infection, cystitis or ascending pyelonephritis, may require hospitalization. Daily bladder lavages with antiseptic solutions, such as 1:2,000 silver nitrate or 1:10,000 Zephiram, or bladder instillations of 2 per cent mercurochome probably are useful in avoiding such complications. During this whole period, provided renal functions is not too greatly depressed, the sulfonamides should be given in repeated courses to avoid infection, or the sulfonamides or pencillin may be used to control established infection. In a small percentage of cases, epididymitis will complicate the situation. Usually it is well controlled by support and continuous hot wet applications. The latter are preferable to the ice bag in all stages of the process.

When it is apparent that improvement has reached its maximum and has come to a standstill, nothing will be gained by further postponement of operation.

Choice of Operation

The choice of operation—transurethral resection, suprapubic prostatectomy, or perineal prostatectomy—must lie with the surgeon or urologist who does the operation. The general practitioner or

family physician—or for that matter, the patient himself—may have a preference for any one of the three procedures and hope that it may be employed. This preference and hope can be expressed intelligently only as a preference for a particular surgeon or urologist particularly talented and skilled in the preferred procedure.

This business of the choice of operation and choice of surgeon or urologist is a touchy business. If I had more tact and less temerity, I probably would say nothing more about it.

Although the choice of operation is not a part of the general practitioner's role in the management of vesical neck obstruction, it is his job to refer the patient to a surgeon or urologist. And so, some comment anent the matter may be to good purpose.

In any case of vesical neck obstruction, it is desirable to employ the method of operation that is best suited to the patient and to his particular form of obstruction. To employ the operation that is best suited to the doctor is still more important. If the surgeon who does the job is not qualified to do it properly, it will not help much to choose the operation best suited to the patient. Both patient and doctor will be better off if the doctor employs the particular operation best suited to his talent, and to his ability to perform it properly, even though it is not academically the operation best suited to the patient and his particular form of obstructive deformity. Certainly mortality, morbidity and general results will be best served if this consideration dictates the choice of operation.

Only if the surgeon's diversity of talent permits may the operation be suited to the patient.

Three methods of operation for vesical neck obstruction are available: suprapubic prostatectomy, perineal prostatectomy and transurethral resection. Each one of the three makes a different demand upon skill, ability, training and experience.

Suprapubic prostatectomy makes the least demand on these. It is a relatively fool-proof procedure. Combined with some degree of general surgical ability and some experience in the procedure itself, it is capable of reasonably good execution in hands of average skill.

A well-performed suprapubic prostatectomy yields an excellent result. Faults in its performance may increase mortality, but the technique is so simple there is little opportunity for technical faults to give a poor result.

Perineal prostatectomy is a tricky and treacherous procedure. It requires intimate knowledge and familiarity with perineal anatomy. It is not just recognition of structure exposed and seen; it is knowing where they are and how not to see them—the lumen of the rectum, for instance.

The really significant merit of perineal prostatectomy is its low mortality. For some reason, there is no shock, and it is peculiarly devoid of the fatal complications that go with the suprapubic operation.

Any surgeon can perform a perineal prostatectomy and no matter how badly it is done or how poor the result, the patient usually recovers. What surgeon is able to do a perineal prostatectomy properly, and regularly secure a favorable result, is another question.

Transurethral resection makes by far the greatest demand on special skill, training and experience. It is a highly technical procedure in which many factors are concerned and determine competence.

All suprapubic and perineal operations are much alike. Anyone competent to do them at all is competent to do them in all cases. This is not the case with resection. Depending on gland size, length of urethra, configuration of deformity, vascularity of tissue and many other factors, resection varies from a relatively simple and easy procedure to one of great complexity and difficulty that will tax the ultimate in skill and resourcefulness.

This fact makes competence as a resectionist dependent on another, somewhat ethereal factor which applies little if at all to the open operation. This factor is the individual's own honest and accurate appraisal of his ability as a resectionist and his willingness, despite the patient's clamor, to limit the procedure to cases that come within the scope of his ability.

In view of all this, it is hard to understand why good old reliable suprapubic prostatectomy is replaced by a new and difficult procedure, forced into hands where it does not belong.

I submit that in the choice of operation for vesical neck obstruction, the first and most important thing is to suit the operation to the doctor. When that has been done, and depending on the doctor's talent and ability in each of the three procedures, the operation may be fitted to the patient.

Only the surgeon himself knows what his skill may be with each of the three procedures. In view of that, one should never prescribe, under any circumstances, the form of operation to be done.

In the hands of the surgeon who is thoroughly competent to do all three operations and is not prejudiced, transurethral resection will be the operation of choice in 85 to 90 per cent of cases, suprapubic prostatectomy in about 15 per cent, and perineal prostatectomy in the remainder.

Such a surgeon or urologist will reserve the suprapubic and perineal operations for cases presenting a degree of technical difficulty to resection. Glands of very large size, abnormally vascular ones, and great elongation of the prostatic urethra make for such difficulty. Among these cases, such a surgeon will have a preference for the suprapubic operation because of the comparatively poorer promise of a good result by perineal prostatectomy in his hands. However, if the patient is very old and decrepit, and a poor surgical risk, perineal prostatectomy will be the operation of choice because of its greater safety.

The surgeon who is fair to his patient and to himself will limit his use of these three operations according to his ability to perform them. Always he will employ the operation which best combines with his particular skill and ability to serve best the welfare of the patient in his hands, whether it be by the suprapubic, perineal or transurethral method.

If we recognize this and are governed accordingly, prostatic surgery will be perfectly individualized in respect to both patient and surgeon, and will best serve the welfare of patient, doctor, medical science and the truth.

Postoperative and Follow-up Treatment

These patients are not fully recovered at the time of discharge from the hospital. To postpone discharge until full recovery would be a needless loss of time and impose unnecessary expense. The patient needs routine follow-up observation and care.

What the end result is to be is never known at the time of discharge. The chief promise of a good eventual end result is absence of residual urine. The presence of some little residual for some weeks following operation, particularly transurethral resection, is of no grave moment. If the operation has been adequate, the residual urine will disappear. So check up on your urologist by frequent residual determinations. If at the end of six or eight weeks residual in excess of 30 c.c. continues, the patient should be sent back for check-up cystourethroscopic examination.

In some cases, persisting residual urine is due to bladder atony and may continue even though the obstruction has been completely relieved. In such cases, mecholyl bromide, or the more recent preparation Furmethide, may be effective in increasing bladder tone and promoting complete emptying. Putting the bladder at rest for a few days with an indwelling catheter along with these drugs is a good plan.

Following any operation for vesical neck obstruction there is always pyuria. It will continue until the surface of resection or enucleation has completely healed and covered with epithelium. Until that has happened there is no use in trying to clear the pyuria. At the end of six weeks with enucleations, and longer with resections, sulfonamides, lavages and other means of clearing the pyuria should be started if pus in the urine continues.

Alkaline encrustation of the surface of resection or enucleation may occur during the repair process. This is due to infection with even splitting organisms and an alkaline urine. Large doses of acidulating drugs such as ammonium chloride are helpful in avoiding this complication. Bladder irrigations with dilute phosphoric acid are useful for the same purpose.

Epididymitis and other complications need no special comment.

MSMS

CHIROPRACTIC

When the VA approved seventeen schools of chiropractic for veterans' education, chiropractors all over the country turned handsprings. If the Federal Government would pay for their training, they reasoned, that was a good argument why the state legislature ought to grant them the right to unlimited practice.—*Medical Economics,* Jan., 1948.

This is the natural and expected result:

H.R. 5468 by Mr. Patterson, of New Jersey, February 19. A Bill to authorize the appointment of *doctors of chiropractic* in the Department of Medicine and Surgery of the Veterans Administration.

Referred to the Committee on Veterans' Affairs.

Comment.—This bill seeks to amend Public Law No. 293, of the 79th Congress—"An Act to establish a Department of Medicine and Surgery in the Veterans Administration" by adding the following *new section* to that portion which states the eligibility of doctors of medicine and osteopathy for appointment in the Department of Medicine and Surgery: "Hold the *degree of doctor of chiropractic* from a college or university approved by the Administrator, be licensed to practice chiropractic in one of the States or Territories of the United States or in the District of Columbia, and have practiced chiropractic for a period of at least two years." Chiropractors are licensed to practice chiropractic in most of the States, and veterans have been educated at chiropractic schools under the GI Act. None of these schools, so far as our information goes, deserves classification as a college or is a portion of a university. The final determination of the worth of the schools is left to the Administrator of the Veterans Administration.

Unusual Forms of Rheumatic Pain

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THE TERM "rheumatism" is loosely used both by physicians and the laity to cover almost any pain occurring in the back, neck, and upper or lower extremities. Because of its vagueness, the use of the word has been severely criticized in some medical circles. However, the employment of such a term seems justifiable. For more specific definitions, physicians use the terms arthritis or arthralgia for pain in the joints, fibrositis or myositis for pain in the muscles, and neuritis or neuralgia for pain in the nerves.

Before unusual forms of rheumatic pain are considered, it might be well to review briefly some of the commoner types of rheumatic discomfort.

Arthritis

The pain of arthritis is largely confined to one or several joints, and this is true regardless of the type of arthritis concerned. It is surprising how much arthritis some people can have without feeling any pain or discomfort whatever. This is particularly true in some forms of osteoarthritis and in certain early cases of ankylosing spondylitis. Even in classic rheumatoid disease, the joints are often free from pain except when they are subject to flexion or extension. One of the prodromata of rheumatoid arthritis is numbness and tingling in the hands and fingers. Pain and swelling come later. Spasmodic contractions of the muscles so frequently seen in active rheumatoid arthritis excite a diffuse pain characteristic of muscle spasm, and this will often disappear or diminish when the spasm is released. The permanent contractures and deformities encountered in the later stages of rheumatoid arthritis can be and often are practically painless. The vague muscular and neuritic pains sometimes seen in rheumatoid arthritis are no doubt referable to the cellular infiltrations which Freund and his co-workers have described in the muscles and nerves of rheumatoid patients.

Spondylitis

I have already mentioned the fact that ankylosing spondylitis, or so-called Marie-Strumpell disease of the spine, can be quite painless. The patient complains of stiffness and limitation of motion, but this may exist with no pain whatever. The absence of pain in some of these cases is perhaps unfortunate, for if pain existed, the patient would consult his physician more promptly. On the other hand, there are many other cases of spondylitis deformans who suffer a great deal of pain. It is this latter group which is receiving so much benefit today from deep x-ray therapy. The pain in Marie-Strumpell disease is often due to muscle spasm, not only in the back, but in the large gluteal muscles. The pain which follows the course of the spinal nerves, particularly of the intercostal type, is no doubt due to pinching of the nerves at their point of exit from the spinal canal.

Rheumatic Fever

The pain of classic rheumatic fever is quite severe, much more intense than that of rheumatoid arthritis. As a rule the pain is sharper in the rheumatic fever of adults than in that of children. Its most striking characteristic is its prompt disappearance after the use of salicylates. However, I have often observed how long some of these patients continue to suffer with low-grade joint and muscular pain after the temperature, leukocyte count and sedimentation rate have all returned to normal. Furthermore, one should not forget the occasional abdominal pain of rheumatic fever, and the prevalent precordial pain which results from cardiac involvement.

Osteoarthritis

Osteoarthritis occurs most commonly in the fingers, knees, back and hips. In the fingers, so called Heberden's nodes can be quite painless except when struck against some hard surface. At times, Heberden's nodes may become red and tender, and are then quite painful. Osteoarthritis of the knees can give a patient considerable discomfort, particularly if he is overweight and thereby placing an unduly heavy burden on the injured joints. The characteristic discomfort in this type

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of patient is noticed most markedly in getting up and down out of a chair and in climbing stairs.

Pain in the spine often results from advanced osteoarthritis, but it is indeed amazing how much osteospondylitis may exist without producing any pain at all. For this reason, it is dangerous to attribute all back pain in middle-aged patients to the universally present osteoarthritis of the spine. The pain which many of these patients experience is due, not to the arthritis, but to bad posture induced by obesity, lack of muscle tone, anatomical deformities, et cetera. I therefore rarely tell a patient with osteoarthritis of the spine that nothing can be done to relieve his discomfort. To be sure, the osteoarthritis is permanent, but postural and other defects may be corrected, and with this correction the patient may lose all or part of his discomfort. I have always contended that osteoarthritis of the hip produced more pain and discomfort than any other form of osteoarthritis. The pain is usually referred to the groin and knee and is extremely resistent to treatment.

Gout

The pain in acute gout is of sudden onset and very severe. It is controllable in many cases only when opiates are administered. It is of short duration, however, when colchicin is administered promptly. The pain in chronic tophaceous gout does not differ essentially from the pain of rheumatoid arthritis.

Bursitis

In regard to the more unusual forms of rheumatic pain, one to be considered is bursitis, the most prevalent form of which is subacromial bursitis of the shoulder. "Painful shoulder" has received much attention from medical writers. Certainly they are not all caused by calcific deposits in the subacromial bursa. Peritendinitis of the long tendon of the biceps explains a good many. Other painful shoulders are due to arthritis. Then there are the scalenus anticus syndrome and two or three others.

Subacromial bursitis at times is an extremely painful condition. The pain originates in the shoulder but radiates down the arm, even into the hand and fingers. Some of these cases respond quickly to procaine injections or deep x-ray therapy. Others are more persistent, and require surgical excision of the inflamed bursa. The operation is usually successful, but I have seen cases where pain persisted for months after the bursa had been removed.

Lumbago, Sciatica and Ruptured Disc

In approaching painful back, the first distinction and the most important perhaps is to differentiate between a backache and a stiff painful back. The most characteristic backache is that which women experience with pelvic and menstrual disorders. The stiff painful back generally goes under the title of lumbago.

Lumbago is frequently associated with sciatica on one or both sides, and this syndrome is now recognized as often due to rupture of an intervertebral disc. The pain produced by ruptured disc can be more or less severe, depending on its location. Some ruptured discs produce only lumbago. Others cause only sciatica. The more typical cases are characterized by both. During the acute stage of the ruptured disc there is much muscle spasm affecting chiefly the erector spinal group. This causes the characteristic lateral tilt of the patient and great difficulty in flexing the spine. The sciatica may be severe enough to require opiates. The pain has the characteristic burning quality of a neuritic lesion and is increased by coughing and sneezing. The pain is often marked over the external aspect of the thigh when the external lateral cutaneous nerve is being pressed upon. For some reason not entirely clear, the pain of sciatica, and indeed of all forms of neuritis, is usually more intense at night than in the daytime.

Fibrositis

Fibrositis may occur in the neighborhood of the joints, as for example, peritendinitis of the shoulder, or it may exist in the muscles of the back or neck, quite independent of any joint or periarticular tissue. Acute wry neck is a good example of fibrositis in the acute form. The pain of fibrositis varies considerably, depending upon the location and severity of the process. Fibrositis is frequently associated with flexion deformities and seems to be particularly common in middle-aged psychoneurotic women.

Psychogenic Rheumatism

A discussion of fibrositis naturally leads to the subject of psychosomatic or psychogenic rheumatism. This prevalent condition takes on many forms and is seen quite typically in so-called tension headache, in which the pain and stiffness are

really in the neck instead of in the head, though headache may be a concomitant phenomenon. A good many articles have appeared since World War II on the occurrence of psychogenic rheumatism in soldiers. Certainly this condition is not limited to soldiers, but forms quite a large part of the material in arthritis clinics or office practice. Hench believes that a differential diagnosis can usually be made between fibrositis and psychogenic rheumatism. The pain of fibrositis is localized and perisistent in one or more sites. The pain of psychogenic rheumatism wanders about in a random sort of way and appears in unusual locations. Furthermore, the pain of fibrositis is readily controlled by salicylates and codeine, whereas the psychogenic patient will rarely admit that any anodyne is effective.

Menopausal Arthritis

Closely related to the preceding group is so-called menopausal arthralgia or arthritis. This type of joint pain is often very severe and is a phase of the menopausal syndrome. The pain is particularly conspicuous in castrates who lose their pelvic organs while still in the twenties or thirties. Ordinarily one encounters these pains in middle-aged women during or shortly after cessation of menstruation. The joints most frequently affected are the knees, the back and the fingers. Sometimes the pains are located in joints which also show an osteoarthritis. There will then be some doubt as to the etiology of the pain.

Occupational Arthralgias

It is astonishing how many pains and aches in the joints and muscles come from some special occupational strain. This is particularly true of pain in the shoulders, elbows, and wrists. Pain in the buttocks may come from driving a car with a stiff clutch or foot brake. Middle-aged individuals who indulge in sports often pay a penalty in the form of stiff back or painful knees.

Recently an elderly patient came into my office complaining of severe pain in the right shoulder and right wrist. Three years previous to her visit she had suffered a hemiplegia of the left side from which she had partially recovered. As she attempted to rise from an armchair in my examining room, I noticed that because of her weak left side she was raising her whole body almost entirely with the right arm and shoulder. I pointed this out to her and urged her to discover some other way of getting up out of a chair, at least for the time being. This she agreed to do, and within two or three weeks the pain in her shoulder and wrist had entirely disappeared. This form of arthralgia and fibrositis could well be classified as traumatic.

Rare Forms of Rheumatic Pain

Palindromic rheumatism is a rare but now well-recognized form of joint pain and swelling, very intermittent in character and of unknown etiology. In this condition, several joints are usually the seat of swelling and redness, and the pain is quite severe. However, after a few days the local signs disappear, and simultaneously the pain goes too, to return again after a few weeks when another attack makes its appearance.

In addition to these frank forms of rheumatism, there are a number of other diseases which are characterized by pain and sometimes swelling in the joints, but which can hardly be looked upon as true rheumatic conditions. I refer to the painful joints of lupus erythematosus, periarteritis nodosa, dermatomyositis and Raynaud's disease. The pain of Raynaud's disease is characteristically accompanied by numbness and can be terminated at any time by immersing the hands in warm water or going into a warm room.

It is important to differentiate between the so-called "rest pain" of thromboangeitis obliterans, which is continuous and usually worse at night, and the pain of intermittent claudication which is produced by activity and relieved by rest.

The pains and aches which accompany paralysis agitans are very real, and the same is true of the bone and muscle pains which one encounters in osteitis fibrosa cystica and Paget's disease. The intense pains in the neck, chest and lower spine which occur with carcinomatous metastases to the bones are easily confused with other forms of rheumatic pain. This is even more apt to be the case when a bone metastasis implicates some large joint, such as the hip.

Therapy

The treatment of rheumatic pain depends largely on the cause. Unfortunately, many of these pains yield very slowly to treatment of any kind. Symptomatic relief can usually be obtained by one of the salicylates, reinforced by codeine or demerol. One must never forget that the patient

(Continued on Page 522)

Diagnosis and Treatment of Scabies

By Eugene A. Hand, M.D.
Saginaw and Bay City, Michigan



THERE WAS considerable apprehension that the demobilization of our world-traveled veterans after World War II would increase those tropical and contagious diseases heretofore rare in this country. Fortunately this was not true for malaria, yellow fever, cholera, filariasis, and intestinal parasites. As with all wars, revolutions, mass immigrations and social upheavals, venereal disease, fungous infections and scabies increased.

Scabies is more common in the colder months, reaching a peak in March and April in this climate. The normal decrease in scabies expected in the summer of 1946 did not occur. This was the result of the demobilization of infested army and navy personnel, pouring fresh scabies into the civilian population. The summer of 1947 saw the normal decrease, but the disease is again on the increase this fall.

The writer's interest was sharpened as a United States Navy, liaison officer with the Australian Army in Perth, Western Australia, during World War II. The unfortunate use of bichromate as a dye for the khaki uniforms and blankets of this superb ally led to many cases of khaki or chrome dermatitis. During early stages of this condition, the presence of general pruritus which was aggravated at night, the same as with scabies, made the differential diagnosis difficult. This was important because the treatments of these conditions are diagramatically opposite. The complications of dermatitis, pyodermas ,and eczematization, often chronic in type, seen from treatment of scabies with sulphur and other sarcopticides, were even more common and distressing when used by error on skin irritated by the bichromates.

Bonomo,[6] of Leghorn, Italy, in 1687, described the finding of the *Sarcoptes scabiei var. hominis* after teasing the female adult out of a scabetic lesion on the point of a needle or pin. This has been the classic method for demonstrating the scabies insect, and is so described in most textbooks on dermatology. This method, which is difficult, time consuming and impractical, has been likened to the difficulty of finding the pot of gold at the end of the rainbow.[2]

The accidental finding of the adult female acarus in a KOH direct examination, while searching for fungus in skin scrapings, led to the routine search for scabies organisms by this method in all cases of suspected scabies. This was most helpful when sulphur had to be used due to a shortage of benzyl benzoate.

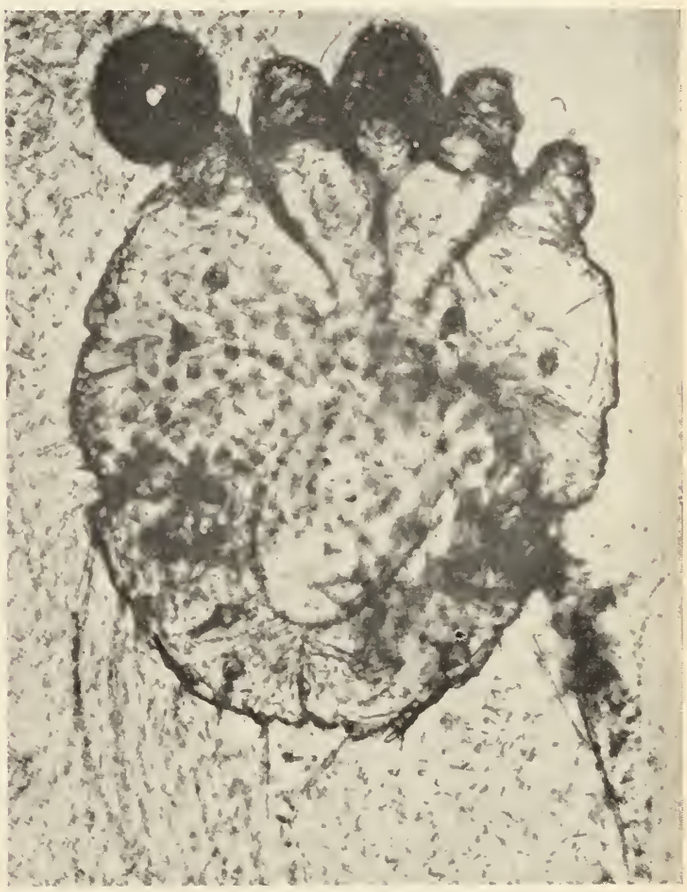


Fig. 1. Adult female acrus. High power.

Friedman[3] in 1942 noted that the acarus could easily be demonstrated by the scrape and smear method, and also that the diagnosis could be made by finding acarus eggs filled with embryo or empty, skeletal parts of the acarus, the larvae, and the scybalae as well as from the adult acarus.

Technique of the Slice, Scrape, and Smear Method[4]

This is a simple method, easily learned. It is important to make a careful search over the affected parts to pick out lesions most likely to give a

Read before the first annual Michigan Postgraduate Clinical Institute of the Michigan State Medical Society, in Detroit, Michigan, March 14, 1947.

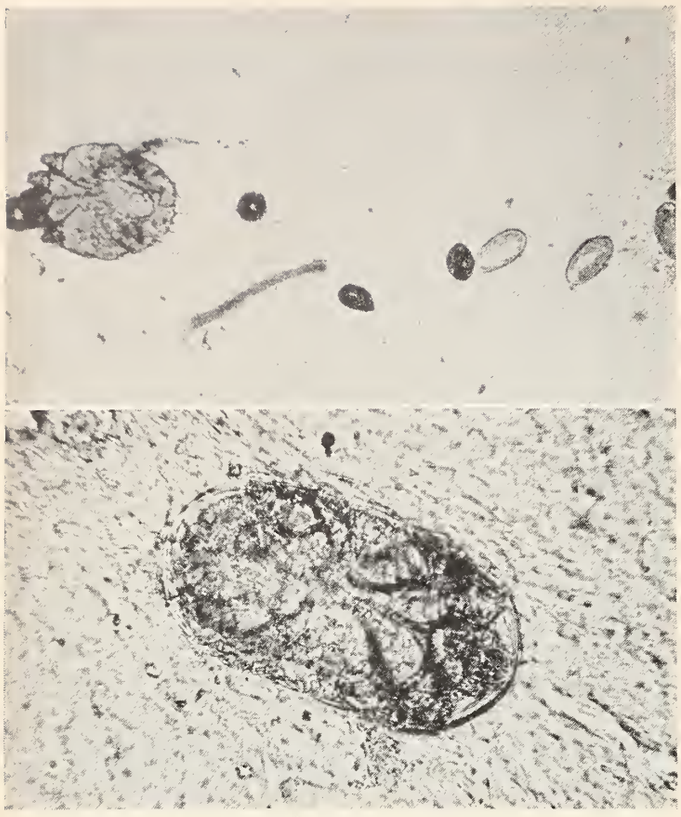


Fig. 2. *(above)* Adult female in burrow with eggs and scybalae. Low power.

Fig. 3. *(below)* Embyro in acarus egg. High power.

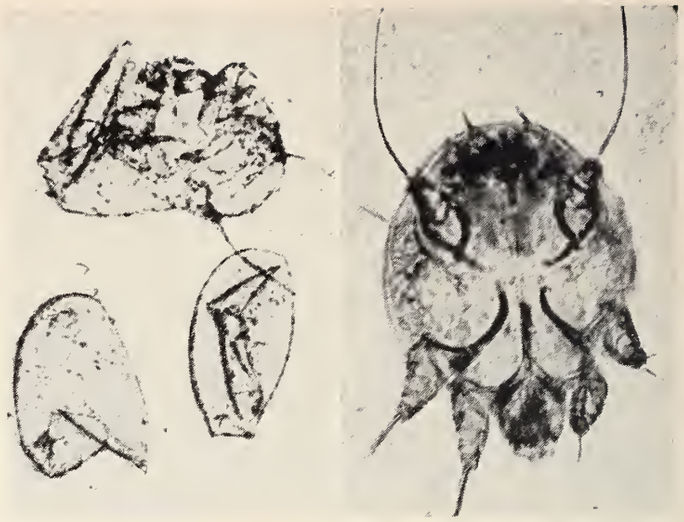


Fig. 4. *(left)* Empty eggs. Hexapod larva leaving egg. High power.

Fig. 5. *(right)* Hexapod larva. High power.



Fig. 6. Skeletal parts of adult female acarus. High power.

positive diagnosis. Here experience is a great aid. Ordinary rules of cleanliness and asepsis should be observed. For lesions on the webs of the fingers, the fingers, and the wrists, a sterile sharp razor blade is used to shave off a very thin slice of the vesicle, pustule, or burrow. For lesions on the abdomen, genitalia, buttocks and other parts less easily reached, scraping of the lesion with the razor or a sterile Barb-Parker knife is best. The slice or scrapings are then transferred to a glass slide, covered with a cover slip and dissolved in 10 to 20 per cent sodium or potassium hydroxide. The slide is then examined under low power, using high power when needed.

Photomicrographs (Figs. 1-6) showing the adult female, hexapod larvae, filled and empty eggs, scybalae, and skeletal parts of the sarcoptes, will be of great help to the user of this method.

Clinical Diagnosis of Sarcoptes Scabei Infestations

A high index of suspicion is most important in recognizing scabies, as with all diseases. It is most important to ask about and examine, if possible, other members of the family and other contacts in suspected cases.

In children, especially babies, the scalp and face are at times involved, which is almost never true in older persons. In babies and children, the sexes are about equally affected. In adults, men are affected about three times as often as women, for some unknown reason.

It is important to examine the male genitals, as the presence of an erythematous papule or burrow on the shaft of the penis or the scrotum is almost pathognomonic. Examination of the genitalia of the sex partner of a woman suspected of scabies often will clinch the diagnosis.

Scabies should be suspected in all cases of furunculosis, as this often masks the underlying scabies. This is also true of ecthyma, pyoderma, and impetigo in children.

The following areas should always be examined: the webs of the fingers, the anterior wrist, the inner and posterior elbows, the anterior axillary

folds, the nipples and breasts in women, the navel and abdomen, the shaft and glans penis in the circumcised, the penis shaft to the external rim of the foreskin in the uncircumcised, the scrotum, the buttocks, and the knees, ankle, and toes.

Though scabies is more common in the poor and unclean, it is found in all classes and in all periods of life. It is spread by contact with infested individuals in most cases. Though scabies may be contacted by handling towels, toilet articles, and other objects handled or worn by a scabetic, this is probably rare. It is usually necessary to have intimate family contact such as sleeping or cohabitating with an infested individual. It probably can be picked up from toilet seats, but again this is doubtful. Dancing and petting are common methods of spread. This disease is a disease of lodging houses, ships, barracks and the like. It is common in prostitutes, and many men are so infested.

Treatment of Scabies

Prophylaxis.—Next to avoidance of those infested, frequent bathing is the best prophylaxis. One should avoid exchanging or using articles of clothing, towels, bed clothes, and sports equipment used by infested individuals. The prophylactic treatment of those exposed to scabies will prevent many new cases.

Treatment of Contacts.—It is primarily important in treating this disease to remember that scabies is a family and community disease. If this is not remembered, scabetics, even though cured, will be reinfected from some other family or other contact, and the treatment will be a failure. This has aptly been described as ping-pong scabies. It is important to treat all infested contacts and to give prophylactic treatment to others who have had intimate contact with the patient.

Treatment of Clothing, Bedding, Towels, et cetera of the Infected.—Even slight personal contact serves to spread scabies. Whether scabies can be transmitted through clothing, blankets, and other indirect contacts is questionable. Mellenby[7] in sixty-three trials, with all conditions favorable as possible, was able to transmit the disease in only two cases through infested underclothing and blankets. Mellenby[9] found that the organism was killed in almost every case within five minutes at 120° F. It is believed that the organisms and eggs are destroyed in a house in one weekend by keeping the temperature at 85° to 90° F. Washing garments except woolens with soap and water is effective in destroying the mite. As the mite is easily killed by high temperature, the use of a hot iron on woolen trousers, skirts, et cetera, will suffice.

Treatment of the Individual.—Space will not permit more than a mention of the scabeticide specifics such as balsam of Peru, Rotenone, betanapthol, styrax, xylene, pyrethreum, gasoline, synthetic sulphur compounds, DDT, et cetera. This paper will be limited to the use of sulphur and benzyl benzoate.

The main problem in treating scabies is to kill all of the adult acarus organisms, the larvae, and the embryo in the eggs, without disabling, injuring, or killing the host. In judging the efficacy of any sarcopticide, one has to determine only two things: (1) Is the preparation effective in killing the acarus elements? (2) Is the preparation, under the conditions necessary for the material to kill the acarus, apt to cause dermatitis and eczematization with accompanying furuncles, pyodermas, and ecthyma?

Blondes and children, particularly babies, are more prone to develop dermatitis. Itching after treatment of scabies may indicate failure in cure, but this is more likely to be due to allergic manifestations (not well understood) from the dead acarus. It may well be the result of the treatment. One should not retreat at once, but use ordinary soothing dermatologic treatments. This is of prime importance. Experience here is vital in handling scabetics. One must expect and diagnose dermatitis from treatment early, then discontinue or change the treatment at once. More chronic skin disease in later life can be traced to injudicious or overtreatment of scabies in babyhood and childhood, than to any other cause.

Sulphur.—Sulphur has been used in many forms. As a powder in the form of flowers of sulphur, it was ineffective, causing dermatitis before cure. Flowers of sulphur has been used prophylactically as a dusting powder in bedding.

Sulphur in the form of sodium hypochlorite with HCl was used extensively by the British. Cure was infrequent and dermatitis common. This method never had any great vogue in this country.

Sulphur in the form of sulphur foam applications[1] and sulphur soap have had an unfortunate

following. Cure with this method is rare, and untoward reactions common.

Sulphur vapor, a revival of an ancient method, was used in World War I. The soldiers wore gas masks during the treatment. The percentage of cure was low in compared to modern methods.

Sulphur in ointment form, especially when incorporated in the newer vanishing cream bases, is cheap, easily obtained, and highly effective. The drawbacks are that it is messy and prone to produce dermatitis and pyoderma in too many cases.

In selected cases, sulphur still is a good form of treatment. A 3 per cent sulphur ointment for babies, a 3 to 8 per cent ointment for children and the fair-skinned, and a 5 to 15 per cent ointment for the dark-skinned is suggested. Usually this should be applied all over, from the neck down, twice daily for three to five days without bathing.

Benzyl Benzoate.—Benzyl benzoate is rightfully the treatment of choice for scabies. This is not a new form of treatment, as this drug is the active substance in the old scabeticide, balsam of Peru. As pernol, it was brought out by Sachs and Juliusberg[10] in 1900. Kissmeyer[5] popularized it in 1937. The great English sarcoptologist, Mellenby,[8] advocated its use during the great scabies epidemic in England during the recent war.

The choice of a vehicle for this drug is most important, as most cases of dermatitis from its use are due to the vehicle. Spirits, soft soap, lanette wax, various of the emulsion bases, calamine lotion, and liniment have been used. Spirits and soft soap were particularly prone to cause reactions on the skin.

It should be remembered, as with sulphur and other methods, that post-scabetic pruritus is more likely due to sensitization factors from the dead acarus or from the treatment, and less likely from failure to cure. Retreatment and overtreatment should be avoided.

A suggested schedule of treatment very effective in my hands, in military and civilian practice, has been the use of 20 per cent benzyl benzoate in calamine lotion, or preferably liniment, applied over the body from the neck down, twice daily for three to five days. It is important to follow the case, so that overtreatment will be avoided. After this course, patients are instructed to avoid soap, to take daily baths, and use nonirritating topical applications for several weeks.

A short two-day course with this preparation, as a prophylactic treatment in those exposed to scabies who might be in the incubation period, has been most helpful.

In babies and the fair-skinned 5 to 10 per cent benzyl benzoate is advocated in place of the stronger preparation.

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UNUSUAL FORMS OF RHEUMATIC PAIN

(Continued from Page 518)

can become addicted to demerol. The quick relief which the patient obtains from aspirin in rheumatic fever, from colchicin in gout, and from penicillin in gonococcal arthritis, is not so readily obtained in many of the other conditions which I have discussed. Gold therapy usually causes some exacerbation of pain during the twenty-four hours following an injection. However, this is noted with only the first few inoculations. The sharp pain of Marie-Strumpell spondylitis often yields brilliantly to deep x-ray therapy. Roentgen therapy is also effective in the acute stage of bursitis of the shoulder. Fever therapy sometimes gives relief, but often this is of a temporary character. For the pain and stiffness of fibrositis there is nothing better than heat and skillful massage, and in many cases one has the feeling that massage is really curative. Hydrotherapy and short wave have an important place in therapy. In many cases, rheumatic pains yield to none of the measures at our command. Time, however, is a great if procrastinative physician, and often the pain will eventually depart as mysteriously as it arrived, leaving the physician in permanent ignorance as to its nature and cause. However, this is still true, not only of rheumatic pain, but of a good many other phenomena in clinical medicine.

33 East 61st Street

Organizing The Secretary's Work

By Horace Wray Porter, M.D.
Jackson, Michigan

WHEN ONE ACCEPTS membership in a state medical society, he should be willing to do his bit in the program and committee work of that society cheerfully to the limits of his ability. I doubt if one could be a good average secretary for his county society without having this sense of obligation.

What will be said here concerns the responsibilities and duties of a secretary of a county medical society having a membership of approximately 110. In smaller societies, it should be that much easier. In larger ones, there would be so much to do that an executive secretary might be necessary on a full-time basis.

All too often a county medical society will "railroad" a newcomer into the office of secretary at election time with the joking remark that "it will give him a chance to get acquainted." Past experience in collecting dues would point to the treasurer's job as the short cut to that goal.

Most doctors, having had to take notes in seven years of college at a supersonic rate, swore off notes eternally when they finally were privileged to wear the green tassel on that ill-fitting square cap with a seven-way-stretched base of attachment. The job of secretary, therefore, seems to be something to be strenuously avoided by any physician. Hence the "railroad" job.

In a county the size of Jackson, there is so much clerical work as secretary that my society pays my private secretary a decent stipend to do the extra work that the job entails. They also have furnished my office with a separate telephone listed under the name of the society. This phone serves as an identification of the organization as an active group; it does not tie up my own phone with society business, and it saves dividing up the expense of calls on my bill as to personal and county business at the end of the month.

The first duty of a county secretary is to answer his mail—especially from 2020 Olds Tower, Lansing. The folks in Lansing cannot run the office of the State Society without the various types of information they need from the component county societies, nor are they mind readers. Making out blanks is anathema to most doctors and is considered as so much red tape. Someone has defined red tape as another man's way of carrying on his business. So the secretary fills out the blanks and considers it as part of the job.

In many cases, only an older member of the society could be expected to know the answers to some of the questions asked. This makes the choice of the youngest member as secretary a poor one to start with, so he is the first to nominate a newer man than he the next year with the same unsatisfactory result.

The time to answer the mail is the day it comes. The knowledge that it has to be answered is both fresh and distasteful, like bitter medicine. Get it over with and everybody is happy—especially the central office.

After it is answered, file your carbon copy where you can find it in a hurry, if necessary, later.

The next important duty of a secretary is to know, or have on record, a detailed history of the educational background of every member in the society. From experience, I can say that the secretary is, can be, and should be a one-man public relations committee de luxe. Someone, at least four times a week, wants to know something about a doctor member in a hurry. The questions may vary greatly:

"Is he a proper man for an insurance examiner (for which job he may either have applied or is being considered)?"

"Dr. ———— is applying for credit in a fairly large amount; what do you know about his financial standing; does he have a reputation for paying his bills; is he reliable?"

"We want a speaker of a certain type for a special occasion. Dr. ———— has been recommended. Would you recommend him?"

"Dr. ———— is mentioned as being the recipient of a recent honor. Can you give us a summary of his general background?"

"We just learned that Dr. ———— died while on a trip. Can you give us a history on him and who survives him; the family are all there with him?"

Many other questions of similar nature pour into the secretary's office, and the association of many of these questions with the newspapers brings up the next important requisite of a successful secretary—

Get acquainted with the editor of your local newspaper and *make him like you.*

Presented at the annual County Secretaries and Public Relations Conference of the Michigan State Medical Society, Detroit, January 25, 1948.

In these days of propaganda for socialized medicine, every conceivable bit of adverse criticism is snapped up, magnified and distorted as a means to an end for the ultimate goal—political control of medicine practice. A good secretary can keep a lot of these half-baked ideas out of his local paper in any town by maintaining the proper relations with his local editor.

Remember, first of all, that the editor's bread and butter is *today's* news. There is nothing so dead as yesterday's news. Furthermore, remember that this newspaper editor-secretary relationship works both ways. You give him all the news you can within the limits of medical ethics, and he will play ball with you.

Editors are human beings. They get sick and want a doctor in a hurry as often as other people. See that they get that service, and you have a friend. They can tone down a news item, about a friend, on any subject to take out the sting. They do have a certain inherent respect for the professions, although they are strained sometimes to keep that respect.

Here, if ever, is public relations at its best and with its greatest power. Public opinion is molded by the press; don't forget it for a moment.

The sympathetic editor knows that playing up a malpractice lawsuit in the papers usually starts an epidemic of other suits. Someone is going to be hurt innocently in such an epidemic—probably irreparably.

Some melodramatic so-called cure may come flashing over the wires. If published "as is," it may lead a lot of sick people astray on false beliefs. Before they can be put back on the right routine, their slim chance for a cure may be lost. The co-operative editor knows if he calls the equally co-operative secretary that he can get a rapid correct appraisal of the new remedy and be guided accordingly in his news coverage—often to the point of total disregard of the subject.

If later events prove that his pre-publication consultation saved him from ridicule, where do you suppose he will turn first the next time in matters of medical interest?

Invite him (or his appointed substitute) to your stag parties and meetings. Play golf with him. Play poker with him. Invite him *and his wife* to your annual banquet. Let him know that you value his friendship and his co-operation and have him trust your opinions. You will soon find that the newspaper men have a code of honor that is hard to equal. If you pass on to him some rather important information as being "off the record," you can bet your last dollar that that's where it will be—off the record.

Without fear of contradiction, it can be stated that no other county in Michigan has had a better understanding existent between the editor of the largest paper in the county and the county medical society than Jackson County.

Next, a secretary must take, and keep, legible notes of all meetings. Who can tell when history is going to be made? It has to be made somewhere and usually is not recognized as such at the time. As a radiologist, it has not always been easy to take notes on eclampsia, headache, the process of sleep, the management of heart disease, or convulsions in infancy. Still, a day in which one hasn't learned something is a day lost.

One remembers most vividly the question of a doctor of the saddlebag days of medicine as to whether x-ray showed inflammation of the stomach and liver. Before an intended sarcastic reply could be softened a little by some mental agility, the old doctor saw two doctors laboriously trying to dig plaster-of-Paris from their nails. He suggested the use of granulated sugar and water as a rinse—the plaster disappeared—and another day was saved.

So, the job involves taking notes and they are best transcribed the next day after the meeting. They are fresher then, and the job is done and out of the way.

These, then, are the major duties of a county society secretary.

The minor duties are many and varied:

1. Greet the speaker or speakers and make them welcome.
2. Greet and introduce guests to the members with whom they will sit.
3. Produce a speaker in an emergency out of a clear sky.
4. Arrange for the dinner menu and remember when it is Friday.
5. Get and keep in good condition a screen, a lantern and a pointer.
6. Have enough seats at the speaker's table.
7. See that the waitresses get tips. They have to be the patients of some of your members; they pay $3.00 for an office call; they're working overtime; be considerate; 10 per cent is not quite enough.
8. See that the head waitress leaves a glass and a pitcher of water for the speaker.
9. Offer your speaker at least his traveling expenses; do it unobtrusively but certainly not by passing the plate

and announcing what it is for; even if you know he will refuse it, give him that courtesy.

10. Write him a letter the next day thanking him for coming. You may need him again and, even if you don't, it never hurts to make a friend. If he took two hours to write the paper he gave, you can at least send him a written appreciation of his work.

11. Know how to spell Furstenberg and what Fred Coller's initials are.

12. Know the names of all the specialists within 60 miles.

13. Have at your fingertips the fee schedules of all the many agencies run by your local, state or national government.

14. Answer as much outside mail as is possible. This is good public relations work. A good illustration follows:

Comes a letter from a young lady in Detroit, asking if the secretary can locate an aunt of hers "in a rest home in Jackson." The writer's mother wants to see the aunt (her sister) before either of them dies. The aunt has been spirited out of Wayne County by her children, and the rest of the family don't know the address. They think it is Jackson.

This was during the war. A list of possible beds in Jackson had been demanded by the state emergency department to be used to evacuate chronic patients from Detroit in case that city was bombed. We had the list made up, classifying the beds—male, female, children—and a copy lay right on the desk. A telephone call was made to the first rest home listed in alphabetical order. "Aunty" was sitting in the dining room right beside the lady who answered the telephone.

A short letter to the niece as to how to get to this rest home on a country road brought back a lovely letter of thanks written in the fine spidery handwriting of an old lady who found and visited her lost sister the following week end.

Good public relations? ? You guess! !

15. Be ready to take all the blame for anything that goes wrong.

16. Don't expect any credit for what goes smoothly. The entertainment chairman for the evening considers that to be his due.

In summary, the county medical secretary should be a hyperthyroid without the disturbing symptoms, a first guesser and not a Monday morning quarterback, and when he steps out of office his records should be ready to carry on for the future, even if he steps out unexpectedly.

Maybe one has to be born to the job, but he should not be elected as a joke. Presidents come and go, but the good secretary carries on.

MSMS

Buy U. S. Savings Bonds

Co-operation with Other Organizations

By Minita Westcott, President
American Trade Association Executives
Chicago, Illinois

I AM HAPPY to have the privilege of appearing on your program with so distinguished a panel, and before such an alert group of men and women interested in the subject of top importance today, *Public Relations.* No matter what our individual concepts of the meaning of these two words may be, we are ready to admit, I am sure, that they connote at least a major attempt on the part of thinking people to meet the challenge of co-operative understanding between groups, some of whose main purposes and interests are identical. In other words, what we are trying to accomplish is complete understanding of common interests.

What we on this panel are trying to spell out, it seems to me, is, first: what media to use; and second, how to use them, to bring about better public relations between the public—all of the different publics—and the medical profession.

My predecessors on this panel have discussed specific media: the newspaper, the radio, and the cinema; and it has been left to me to discuss as another medium, a perhaps less-used but certainly just as powerful a medium, that of co-operation with other organizations.

This is a tool of public relations in which I am particularly interested because, as you know, my profession is that of a trade association executive, and because this year, I have the honor and privilege of being the president of the professional society of trade association managers, the American Trade Association Executives.

We could discuss the whole broad field of co-operation with other organizations who have some of the same basic interests and purposes, but in order to be valuable and also to bring my presentation within the time limits imposed today, I should like to get right down to cases and immediately examine the important interests of your group which will be common interests of other organizations in a few of the fields with which I am familiar.

Presented at the annual County Secretaries and Public Relations Conference of the Michigan State Medical Society, Detroit, January 25, 1948.

The important interest of the Michigan State Medical Society is naturally *health and its maintenance*. That is one of the most important if not *the* important consideration throughout the whole gamut of organizations in business, education, and community spheres.

Health and its maintenance embrace the significant components of: physicians and surgeons; medicine; hospital care; nursing service; nutrition and safety, to mention the most familiar to the layman. Let us then take health and its maintenance as our common interest, and see how we can secure the understanding and co-operation of other organizations in a public relations program.

We have our "common denominator" now. Shall we look next toward what groups will have the most interest? Your medical societies have already integrated into your program the county, state and national organizations in your own field, so now it remains to us to discuss alliance with organizations in other important realms: (1) civic and community interests; (2) business and industrial interests; and (3) educational interests.

Examples of accomplishments in your own field will help us, I think, to visualize what can be done in these other fields. The establishment of such conferences as the Michigan Rural Health Conference in which thirty co-sponsors joined with the Michigan State Medical Society to consider rural health problems is an excellent example of how co-operation properly directed can bring results. The development of community health councils, such as recommended by your Rural Health Committee, can do much to carry on the same type of co-operation on the local level as was evidenced by the Rural Health Conference on the state level. Interest created by the activities of community health councils can aid greatly the community enrollment plan of such organizations as Blue Cross which when it reaches its maximum extension *could* obviate serious activity for some of the threatening and, to many of us, frightening ideologies.

For civic and community interests, there is the great Chamber of Commerce of the United States with its wide programs covering the problems of civic and community development, including health, nutrition and safety projects. Co-operation with this organization in many of its already established departments and committees ought to yield good results in public relations activities in the field of health and medicine.

For business and industrial interests, there are many well-known and highly developed organizations with which you can work. The first one I shall mention, of course, is the American Trade Association Executives, which is an organization of some 1100 trade association directors representing practically all of the industries in our country . . . manufacturing, distributing, service, and professional groups. Then in addition to the Chamber of Commerce of the United States, already mentioned, there is the National Association of Manufacturers representing the manufacturing interests of our country, large and small, and the American Management Association, whose membership is composed of management personnel of all types of business concerns. Probably these organizations represent the vast majority of the workers in our country. Imagine, for example, what all of the individual companies or concerns represented by these four organizations could produce and distribute and service in a year's time if you doctors discovered a perfect specific or preventive for the common cold. Add to the common cold the countless other diseases that make for absenteeism in industry, which cuts down production and working days by an alarming percentage, and I need not tell you how important health and medicine are to the members of these organizations.

Then, there is the important subject of nutrition, a very definite interest of yours and ours in business and industry. I doubt if America has ever been more nutrition-conscious than now; certainly both the medical people and the trade associations of the country have had their part in creating this interest. Think of the many associations which have tie-ins with medical and allied sciences; as an example, just look at the American Meat Institute's nutritional advertising statements, all of which are approved by the American Medical Association Council on Foods and Nutrition; and the programs of the Meat Institute and many other associations for research carried on in the field of nutrition—National Confectioners' Association and the National Restaurant Association programs, to mention two more.

Policies regarding sick leave, hospital care, nursing care, and a multitude of services for the better health, happiness and ease of mind of workers in industry are a major concern of the companies who are members of these organizations we have already mentioned. Co-operation with them on many phases of these important services should be a

"must" of the medical groups whose major concern and knowledge this field is.

Then, still under business and industrial interests, there are the broad, excellently planned and executed safety programs of communities, civic groups, trade associations, and the National Safety Council. Medical people certainly have a direct interest in safety. Perhaps it rightly comes under the heading of preventive medicine, one of your big interests today. An over-all public relations program, particularly in industry, is a constant necessity in the field of safety work. A study of the wide scope of programs already under way in these organizations just named, with advice and counsel and co-operation on your part in making them more effective, would certainly be welcomed.

Getting down to the third field I mentioned, that of educational interests, we have a fertile field here, surely. Education in the functions and media of public relations in all of our colleges and schools for higher education may be a high goal, but I believe, too, it is a challenge of great importance. Did you know that there has recently been established the first School of Public Relations in a university . . . after twenty-five years of organized public relations programs in business and industry? Boston University established the Boston University School of Public Relations in 1947. It is composed of four divisions which co-ordinate in authority and responsibility: Public Relations, Journalism, Radio, Speech, Motion Pictures, and Visual Aids. In announcing the new school, the University has this to say:

"The significance of the school lies in the scope and integration of training which it provides. Public relations represents an all-embracing conception of human relationships, impinges upon all media of social communication, and contributes to their development. The four divisions of the school represent, therefore, specialized fields in which each division is enriched and strengthened by close relationships with the others. The Division of Public Relations gives new academic recognition to the emerging profession for which it is named, and provides instruction and training leading to public relations degrees."

Thus in dealing with public relations, your profession is dealing with a new profession and can give much from your own experience and knowledge in the greatest of all professions, medicine.

For a moment, I should like to get back to the American Trade Association Executives and one of the most important phases of its program for this year, which I am sure will interest all of you keenly. For the first time in its history of twenty-eight years, it is co-operating with the National Industrial Council, which is the trade association division of the National Association of Manufacturers, and the Trade Association Department of the Chamber of Commerce of the U. S. in establishing a joint committee to formulate a program to broaden public understanding of the place of the trade association in the American economy. In other words, these three organizations in business and industry are working together through a joint committee to educate the public on the vast contributions for better living which trade associations have been making to the public, through product improvement, research, improved manufacturing, improved distribution, advertising, and all of the phases of bringing products and services to the ultimate consumer. This, I think, is a most notable example of co-operation with other organizations, and I believe we can continue to point through the years with pride and satisfaction to the accomplishments of this committee in the field of public relations.

I should like to quote one of the members of our joint committee, Robert E. Harper of the National Association of Ice Industries. He says:

"What is the association's place in public relations? The current and continuing world situation calls for courageous and enlightened business leadership that is ready, willing and able to challenge or defend the human motives and moral principles that underly the theme and scheme of our economy. New adjustments between business and a changing public psychology must be anticipated by forethought—not patched up with afterthought. Organizations—both business and professional—can achieve public good will, but only as their leaders learn to interpret themselves and their organizations broadly in terms of the public welfare. That seems to me to be both a public relations assignment and an association job! Any tough-minded examination of realistic values will clearly indicate the American association as the most effective and dynamic public relations mechanism available today. And, whether we like it or not, we who spin the wheel of fortune for our respective organizations must admit that better than 90 per cent of all of our ideas, plans and actions is wrapped up in the public relations package."

I could talk for very much longer on the wide horizons I can see for co-operation with other organizations in the field of Public Relations, but I hope what I have sketched briefly will serve as a key to unlock many new doors for your own thinking on this challenging subject.

Detroit Physiological Society

Joint Assembly of the Detroit Physiological Society and Wayne University Chapter of Sigma Xi, February 24, 1948

Biophysical and Biochemical Characteristics of Viruses.

Max A. Lauffer, Jr., Departments of Biophysics and Virus Research, University of Pittsburgh, Pittsburgh.

In 1935 Stanley, by using chemical methods analogous to those used for the purification and crystallization of proteins, isolated a crystalline nucleo-protein possessing the properties of tobacco mosaic virus. It was soon recognized that this material possessed an unusually high molecular weight. Therefore, it was possible to devise a procedure for the purification of tobacco mosaic virus through the use of high speed centrifugation. Other viruses have since been obtained in relatively pure form through the use of these methods perfected in the study of tobacco mosaic virus. One of these is the agent causing influenza.

Electron micrographs have shown tobacco mosaic virus protein particles to be rod-shaped bodies about 270 mu long and about 15 mu in thickness. X-ray diffraction data established the thickness more precisely at 15.2 mu. Influenza virus particles, on the other hand, appear as spherical bodies about 115 mu in diameter.

It was found that the sedimentation rate of tobacco mosaic virus varied with the virus concentration. When the reciprocal of sedimentation rate was plotted against tobacco mosaic virus concentration, a straight line was obtained. It was finally realized that the relationship between reciprocal of sedimentation rate and concentration was quantitatively almost identical to the relationship between specific viscosity increase and tobacco mosaic virus concentration. Thus, it seemed reasonable to conclude that the sedimentation rate of tobacco mosaic virus particles was inversely proportional to the viscosity of a tobacco mosaic virus solution. It was later observed that the reciprocal of the sedimentation rate of influenza virus depended upon the virus concentration. This led to the prediction that influenza virus preparations had a high intrinsic viscosity. When the viscosity was measured, it was found to be high as anticipated. Since a suspension of spherical particles should have a low viscosity, it was necessary to assume that a highly viscous contaminant was present. Normal chicken embryos were shown by Knight to contain such a substance. Hence, it was concluded that influenza virus preparations obtained from chicken embryos probably contained a trace of this material characteristic of normal embryos and that this trace was sufficient to impart a high viscosity to the virus preparation. This conclusion was proved correct by intensive fractionation procedures. Thus, viscosity was established as a sensitive index of the purity of an influenza virus preparation.

The ultracentrifuge was used to determine the homogeneity of the virus preparations. It was shown that some tobacco mosaic virus preparations are composed of a single family of particles with a distribution of lengths about a mean and others are composed of two or more families of particles with appreciably different sedimentation rates. The particles with higher sedimentation rates are produced by end to end aggregation of the basic virus units. Influenza virus particles were found to consist of a single family with a distribution of diameters about a single mean.

The ultracentrifuge was also used to determine the density of the virus particles in solution. Sedimentation rate depends upon the difference between the density of a particle and the density of its medium. When the density of the medium is the same as the density of the particles, sedimentation in the ultracentrifuge cannot occur. By studying the effect of various concentrations of serum albumin upon the sedimentation rate of a virus, in the manner introduced by Sharp and associates, one can determine the medium density in which the virus will not sediment. This is equal to the density of the wet virus particle. With knowledge of the density of the wet particle and density of the totally dried material, one can easily determine the amount of water associated with the virus

particle. It turned out that influenza virus and tobacco mosaic virus are both composed of roughly ⅔ water and ⅓ dry material.

From the sedimentation rate and the wet density, the diameter of influenza virus spheres was calculated to be about 115 mu. Through the use of viscosity data in conjunction with sedimentation data, a tobacco mosaic virus particle hydrated to the extent of 67 per cent can be calculated to be a rod about 250 mu in length and about 30 mu in diameter. X-ray evidence shows that dry tobacco mosaic virus particles can add water in such a way as to increase only the thickness of the particle and not the length. Thus, one can calculate from the water content of a wet tobacco mosaic virus particle and the shape of the dry particle obtained from electron microscope and x-ray data a value in excellent agreement with that obtained by means of sedimentation and viscosity data. This affords a direct experimental check on the validity of the equations used to determine shape from viscosity.

One of the urgent questions in virus research is the establishment of the identity of an infectious agent and a particle representing a purified preparation. The ultracentrifuge has been useful in helping to establish such identities in the cases of tobacco mosaic and influenza viruses. Through the use of a special separation cell, which permits samples to be withdrawn after centrifugation, it is possible to measure the sedimentation rate of the biological activity. This value can be compared with the sedimentation rate of the particles obtained by purely physical means. If the two coincide, one knows that the biological activity must be associated with particles of the same general character as those representing the virus preparation. This is strong positive evidence in favor of the assumption that virus activity is actually associated with the physical particles being characterized. Such experiments have provided strong evidence for the identity of the active principle of tobacco mosaic virus and the rod-shaped nucleoprotein particles found in purified preparations. Also, such data have afforded strong confirmation of the belief that the infectious principle of PR8 influenza A is a property of the spherical bodies about 115 mu in diameter.

Session of March 25, 1948

Plasma Volume and Total Circulating Proteins in Cirrhosis of the Liver.

Glenn I. Hiller, Elston R. Huffman and Stanley Levey, Department of Medicine, Wayne County General Hospital, and Department of Physiological Chemistry, Wayne University College of Medicine.

Twelve patients known to have advanced Laennec's cirrhosis of the liver uncomplicated by jaundice and other significant disease were used in this study. Biopsies of the liver were obtained in 10 of the patients. Quantitative protein regeneration was studied by means of simultaneous determination of the plasma volume (T-1824) and the various serum protein concentrations at appropriate intervals of time. Data were collected as the patients improved or failed under treatment which included a diet containing 120 or more grams of protein, 2.7 or less grams of salt and in excess of 3000 calories. Each patient possessed low concentrations of albumin in the serum and exhibited persistent evidence of liver damage, as determined by repeated hepatic function tests, throughout the entire period of study. Individual periods of observation extended from 63 to 280 days in ten of the patients.

The plasma volume was more than 10 per cent above predicted normal values in 82 per cent of eighty-three determinations. It was more than 50 per cent elevated in 36 per cent of the determinations. The normal value for plasma volume was estimated according to height.

The concentration of albumin in the serum was above 3.9 grams per 100 ml. in only 8.6 per cent of eighty-two determinations. At the same time, the quantity of total circulating albumin, calculated from the concentration in the serum and the plasma volume, was normal in 41.0 per cent of seventy-eight determinations.

Similar relationships, although not as striking, existed between concentrations and total circulating quantities of total protein and globulin.

Four patients showed remarkable improvement, as evidenced by the disappearance of edema, ascites and anemia and a return to normal of the nutritional state, despite the continued presence of low concentrations of albumin in the serum and persistent liver dysfunction as deter-

mined by a number of hepatic function tests. Three of the patients have remained in this improved state and are ambulatory five months following discontinuance of the study. In each instance this improvement could be correlated with ability to synthesize and maintain a normal quantity of total circulating albumin. The remaining eight patients are either unimproved or have expired. None in this latter group was able to synthesize and maintain a normal quantity of total circulating albumin.

These data stress several observations and possible explanations. The elevated plasma volume in any given patient was sustained and not greatly altered by disappearance of edema, ascites and anemia. This would indicate that a large portion of the elevation is due to the collateral vascular bed which develops secondary to portal obstruction. No relationship between plasma volume and the various proteins, either concentrations or total circulating quantities, was found to exist. The degree of proteinemia, as measured by concentrations in the serum, was masked by sustained elevations in the plasma volume. It is suggested that ability to synthesize and maintain a normal quantity of total circulating albumin is an important factor in the prognosis of cirrhotic patients. It is also suggested that the cirrhotic liver is capable of protein synthesis to a degree usually not recognized.

Glutamic Acid and Its Relationship to Toxic Symptoms Following Intravenous Amino Acid Alimentation in Man

Charley J. Smyth and Stanley Levey, Wayne County General Hospital, Eloise, Michigan.

Glutamic acid has been indicated as one of the agents which is responsible for the production of nausea and vomiting when casein hydrolysates are given intravenously. To investigate this possible relationship further, the determination of the glutamic acid content in five different amino acid preparations was undertaken using microbiological assay procedures of Dunn. In addition, the apparent free glutamic acid content was determined in the serum of the patients before they received infusions of amino acids and again at the end of the injection or at the time vomiting occurred. The second blood sample was withdrawn from the arm which was not used for the infusion.

The amino acid preparations investigated were: an acid hydrolysate of casein, an enzymatic digest of casein, a hydrolysate of a bovine blood protein, a mixture of amino acid which was prepared by the recombination and fortification of fractions of a digest of casein, and a mixture of the ten essential amino acids plus glycine. The glutamic acid content of the various preparations was found to range between 5.05 to 0 gms. per unit infused.

The preparations which contained a higher glutamic acid content produced nausea or vomiting in a greater percentage of the subjects tested than the preparations low in glutamic acid. The amino acid mixture consisting of the ten essential amino acids has never made any subjects ill.

With an increased glutamic acid level of the serum there was associated an increased incidence of nausea or vomiting. With the preparations low in glutamic acid there was a smaller elevation of the blood glutamic acid level and a concomitant decrease in the number of patients who became ill.

The relationship between the serum apparent glutamic acid level and the occurrence of nausea and vomiting was demonstrated by plotting the serum glutamic acid level of the patients against the per cent of the subjects having this level who became nauseated or vomited. With serum apparent glutamic acid levels below 12 mg. per cent only a few subjects became ill. When the serum apparent glutamic acid level reached 12 to 15 mg. per cent, 60 per cent of the subjects tested became ill. On further increase of the glutamic acid level to values of 16 to 25 mg. per cent, 75 per cent of the patients either became nauseated or vomited. When the serum glutamic acid content reached 26 mg. per cent or higher, 89 per cent of the subjects tested became ill.

The production of nausea or vomiting by intravenous alimentation of protein hydrolysates is directly related to the glutamic acid content of the preparation.

Experiments with Antagonists for Niacin, Pyridoxine, and Pantothenic Acid.

O. H. Gaebler and William T. Beher, Henry Ford Hospital, Detroit.

If a substance antagonizes the effect of one of the water-soluble vitamins required by the dog, one might expect it to interfere with gain of weight in puppies, to cause nitrogen loss in adult dogs, and, in certain instances, to accentuate the

(Continued on Page 544)

Committee Work

The importance of committee work in the present organizational setup of the Michigan State Medical Society can scarcely be overestimated. The committee members are appointed from various parts of the State. They bring together for group thinking some of the best minds in the big towns, smaller towns and rural areas. They do the groundwork on most of the important problems that come before the Society.

It is routine procedure to refer each question that arises to the proper committee for study. After the committee has met, it reports its findings with recommendations to the Executive Committee of the Council, which meets once a month, more frequently if necessary. If the matter under consideration is non-controversial, and the recommendations clear-cut, it is approved by the Executive Committee and becomes effective immediately. If not, the proposal may be rejected or it may be referred to the full Council for more general discussion. The Council meets four times a year and decides on such items as it feels properly come within its scope. Policies that are of unusual importance or extremely controversial are referred to the House of Delegates for decision. It would seem that using these methods, we should make few serious mistakes.

The members and the officers of the Society are deeply indebted to the many committee members who serve so faithfully and so well.

P. L. Ledwidge

President, Michigan State Medical Society

President's Page



Editorial

CONTROL BY INFILTRATION

DIRECT ATTACK seems to have been laid aside for the time being by the coterie of socializers who are bent on gaining power by the simple expedient of gaining control of the health facilities available to the public. The efforts in favor of the Wagner, Murray, Dingell bill have relaxed. In fact, now the bill is even sponsored by that list, but has a number of new names. The efforts at compulsory or universal medical and health services are directed elsewhere.

The attack is more subtle, the latest being a Bill, S. 1290, on National School Health Service, "to establish and develop school health services for the prevention, diagnosis and *treatment* of physical and mental defects and conditions in children" (see page 486). There can obviously be no objections to the purpose of the bill unless one wishes to assume an ungracious position. Hearings are called suddenly when only those "in the know," and who are favorable, are available to testify. No opposition being shown, the hope is for a favorable action of the committee, and of Congress.

Another sample is the National Health Assembly called for May 1 to 4 by the President's direction to Federal Security Administrator Ewing, notice of which we carried in the last number of THE JOURNAL. This conference originally was called with a named Executive Committee of twenty-seven, only one being a Doctor of Medicine, who of all the members might be expected to know something about National Health. After many protests, more M.D.s have been added.

Our observers are cautioning more and more that the attack is by joining and controlling, by infiltration, by the method which during the War came to be known as the fifth column. Members of the profession are becoming more fearful of every worthwhile undertaking which might suffer at the hands of purposeful advocates who wish only to gain opportunity and to seize power. The latest fear to be expressed in this line is of Blue Cross and Blue Shield being taken over by the bureaucratic group who must have some objective to keep them in office, and who are now working on the socializing of the nation's health service.

BLUE SHIELD-BLUE CROSS CONFERENCE

FOR THE FIRST TIME in the history of either movement, a joint conference of Blue Shield and Blue Cross plans was held in Los Angeles from March 29 to April 1, 1948. The conference marked the first appearance of Dr. Paul R. Hawley as chief executive of the Blue Shield and Blue Cross Commissions. Approximately four hundred representatives of Blue Shield and Blue Cross plans of the United States and Canada were present. The primary work of the conference was to co-ordinate the joint activities on the national plane for orderly and impartial administration. But the suspicion of all movements for good, that they might be converted to ulterior purposes, and the innate suspicion that all was not as represented came close to failure for the whole plan. Ten states of the Northwest had a set of resolutions to govern all action that might be taken. Individuals expressed their opposition to joint action, and expounded their fears. But oil was finally poured upon the "troubled waters." Discussion continued for two days and a half without allowing those who were working on the organization plans a chance to explain what it was all about.

A speech by Kay Kayser and a thorough ridiculing brought the adoption of a set of controlling rules, and harmony prevailed. The fear was expressed that the Blue Cross and Blue Shield movement might become so thoroughly successful that the government planners would take it and operate it from the compulsory angle.

That ultimate end we do not fear, if the medical profession and the hospitals can continue to trust each other, can continue to do a magnificent job of administering a mammoth public trust. The medical men have shown their ability, have sacrificed time, effort, money, and by working together have proven to about forty million people that compulsory health service is not needed.

But one thing more is necessary. We must prove our own belief in our accomplishments. There is no excuse for any medical organization, especially a dominant one, to fail to co-operate in our advertised and well-understood ideals. Such an organization should use Blue Shield and Blue Cross benefits for its employes.

PREPAYMENT NON-PROFIT HEALTH PLANS

MANY YEARS have gone since the first attempts to gain control of health services in an effort to grasp great power over masses of people. Bismarck was one of the first. The movement came to America and resulted in much worry, much opposition, but all poorly directed. Doctors and their societies objected, wrote letters, interviewed, and made little progress. The social schemes kept going, gaining a little here and a little there, and becoming ever stronger entrenched in permanent federal positions, positions of impregnability, because of the bureaucratic relationship.

Ten or so years ago medical men began asking the American Medical Association for leadership, for direction of what to do. We were tired of always being "in opposition." We were told this was a local matter, and must be solved on the state and county level.

Studies were made in scattered locations, and many hit upon the idea of some form of prepayment health service or insurance. Many states worked at it, alone, without help, but they evolved a great American institution, and established methods of meeting the catastrophic health crisis which so often strikes a family. No one knew this problem better than the doctor, and it is to his credit that the answer was found. Strangely, this came from the lower level. The American Medical Association entered the field only in 1943 when it established the Council on Medical Service.

This almost universal program, covering nearly the whole United States has become in the words of Senator Vandenberg a "GREAT PUBLIC TRUST." Its problems are far reaching, and becoming too complicated for local or statewide administration. For that reason the National Commissions of Blue Cross and Blue Shield selected General Paul R. Hawley as a joint executive head, to co-ordinate the joint activities of the two groups of Service Plans.

ON THE RUN . . .

Combinations of Streptomycin with one of the sulfones enhances the action of each in the treatment of tuberculosis in guinea pigs.

. . .

The brain of the animal organism approaching death can quickly elaborate substances with extraordinary restorative powers.

. . .

An overdistended bladder may bleed when rapidly emptied.

. . .

Nearly 50 per cent of patients with persistent achlorhydria and a gastric ulceration have cancer of the stomach.

. . .

From 2 to 4 per cent of all cases of pancreatitis are of traumatic origin.

—Selected by Wm. S. Reveno, M.D.

AMERICA'S SECURITY LOAN—OFFICIAL COPY POLICY

Dates.—April 15-June 30, 1948.

Slogan.—AMERICA'S SECURITY IS YOUR SECURITY. BUY U. S. SAVINGS BONDS NOW!

Theme.—U. S. Savings Bonds are security bonds. Individuals provide for their own individual security when they invest in U. S. Savings Bonds, and at the same time they help to maintain the economic security of our country. Funds reserved by millions of American families mean homes, education of their children, emergency funds, and old age security. They mean that these millions of American families are themselves investors —"capitalists"— guiding their own future and the future of the Nation. The success of the Security Loan, and the continued success of the U. S. Savings Bonds Program, means more Americans will own more of America. Americans who own these securities (E, F, and G Bonds) have an actual stake in the operation of their government.

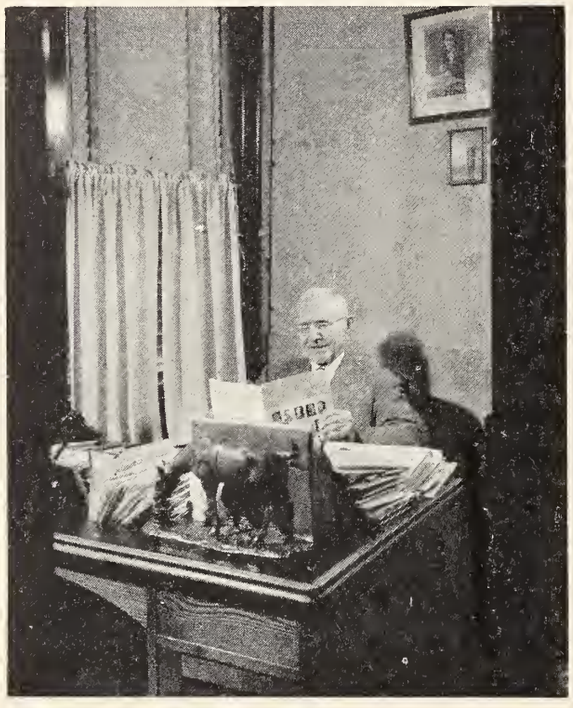
Purpose.—Why is the vigorous sale of Savings Bonds necessary? For two years the Treasury Department has had a successful Savings Bond Program. The national debt has been reduced over $20 billion from its wartime peak. The amount outstanding today held by individuals—$52 billion—is a huge reserve of buying power, and every dollar added to this reserve is a dollar temporarily channeled away from the Nation's market places. At the same time it is a dollar stored away and these dollars . . . billions of them we have saved together . . . can help keep "hard times" away from our door.

The success of the Security Loan will mean, as the economists call it, "spreading ownership of the securities on the national debt." Every Savings Bond dollar built up in your Treasury is used to pay off a dollar of the national debt that is potentially inflationary. This is wise debt management. TOMORROW—the dollars in these Bonds of Security will be ready to help Americans buy the things they need. This helps to maintain a stable economy.

Thomas Edward DeGurse, M.D.

Michigan's Foremost Family Physician of 1947

The Council of the Michigan State Medical Society, at its annual session of January 23-24 in Detroit, created the "Foremost Family Physician Award" covering general practitioners of this state. This award is to be presented annually to the Michigan Doctor of Medicine who is nominated by the Michigan State Medical Society for the AMA General Practice Medal.



Dr. DeGurse keeps abreast of his swiftly moving science.

For the 1947 Award, The Council selected Thomas Edward DeGurse, M.D., of Marine City, who was presented with the Michigan award on March 10, 1948, on the occasion of the second annual Michigan Postgraduate Clinical Institute.

His Accomplishments in Brief

M.D., Wayne University, Detroit, Michigan; postgraduate work, Flint, Michigan, Mt. Clemens, Michigan; staff member, Port Huron Hospital (20 years) and St. Joseph's Hospital, Mt. Clemens (six years); U. S. Medical Examiner, U. S. Marine Corps, 1906; surgeon for Detroit Rapid Railway, 1900-1930; Acting Assistant Surgeon, U. S. Public Health Service; local physician for Michigan Bell Telephone Co., The Detroit Edison Co., Motor Valve & Mfg. Co., Pittsburgh Steamship Co., Standard Products Co., Detroit Gasket Mfg. Co.; Chairman of First Aid Teaching, Red Cross, St. Clair County, (three years); Health Officer (35 years); first Public Health Officer, St. Clair County, 1920; Member, American Medical Association, Michigan State Medical Society (Councilor for seven years, still acting), St. Clair County Medical Society, and Industrial Surgeons. Surgeon to local Draft Board, World War I; Chairman of Appeal Board of St. Clair, Macomb and Sanilac Counties, 1941. Present Hospital affiliations: Port Huron, St. Joseph, Mt. Clemens, and Mt. Carmel, Detroit, Michigan. Especially interested in preventive medicine.

His Biography—A Life Full of Rich Experiences

For more than fifty years, Dr. T. E. DeGurse has combined a fulltime general practice with a record of public service which, in itself, has been a complete career, either one of which could have constituted the life work of any lesser man, with honor. His activities for civic betterment through health improvement have been of inestimable value to his community, and rank him not only one of the great men of his State, but of the whole country.

In his little town of Marine City, Michigan, he has fought not only disease and poverty, but prejudice, ignorance, city councils, and, in one instance, the Congress of the United States, to make his community a better place for his people to live in. And, unlike so many other crusaders, he has lived to see the results of his work, in a whole area free of typhoid and diphtheria, in a thriving town supported by industries which he himself brought in, serviced by good roads which were built during his nine terms as Mayor of the city, peopled by three generations of patients who respect, trust, and adore him. He is more than a public servant and more than a general practioner. He is both.

* * *

Thomas Edward DeGurse was born on July 18, 1873, one of ten children. His people were farmers, and he learned hard work when only a boy. After his mother's death and his father's remarriage, he left home at the age of nine and went to live with an elder sister on a farm, doing chores

to earn his way. At fourteen he hired out as a hired man, farming in summer and lumbering in the woods in winter. At sixteen he left the farm and joined a brother who was a Civil Engineer for the City of Windsor. He worked with his brother as a chainman until he had earned and saved enough money to attend Assumption College and then the Detroit College of Medicine (now Wayne University).

In spite of financial hardships, Thomas DeGurse received his M.D., at the age of twenty-three, and opened an office in Marine City in 1895 for the general practice of medicine.

Marine City is located on the St. Clair River, which connects the upper three with the lower two of the Great Lakes. Traffic on the river was heavy, and resorters and touring fishermen added to the local revenue. But Marine City was not a wealthy town. Its living came from farming, lumbering, salt producing, and five yards for the building of wooden ships. While the town was influenced somewhat by nearby Detroit (forty miles away), it was never a "suburban" city.

Living conditions were as primitive as in any other rural community. The nearest hospital was twenty miles away, at Port Huron. There wasn't time, with the transportation of that day, for Dr. DeGurse to get his patients to the hospital. He did emergency surgery himself, under whatever conditions happened to exist. About 99.4 per cent of his babies were delivered in homes on straw ticking, featherbeds or kitchen tables. His first delivery was done on a pile of straw in a livery stable for a poor girl who had crawled in there with no other place to go. But in all his practice (and he has brought close to 4,000 babies into the world), Dr. DeGurse has never had a case of infection. General practice in those days required considerable improvisation. When a premature baby needed incubation, Dr. DeGurse rigged up his own incubator by opening the oven door of the old wood-burning stove, took out the racks, wrapped the baby in blankets, and placed it in the oven. And his babies lived.

Fees in 1895 were 25 cents for office calls, 50 cents for home calls, and $5.00 for confinements. But about half the time the doctor "forgot" to send bills, knowing that his patients could not pay even those modest fees. (When he moved his office from his home in 1926 to the downtown office where it is still maintained, he threw away $150,000 worth of unpaid accounts.) Nor did his charity stop with free care of his patients. Old-timers in Marine City say that it was a common sight to see him on the way to a patient, loaded down with coal, food, and sometimes blankets,



T. E. DeGurse, M.D., in 1896, twenty-two years of age, didn't seem "old enough" to be a doctor—hence the beard.

for the sick one and his family. (Today, he has a "deal" with the local clothing merchant to furnish clothing to needy patients. The bills are sent to the doctor, discounted of course, and the recipients are never told where the help comes from, though probably they have strong suspicions.)

Transportation in the early years of the doctor's practice was difficult. The roads were bad, and Dr. DeGurse made his calls on a bicycle, on horseback (which he preferred), by rowboat and in winter by sled boat across the frozen river. In the spring when the ice was breaking up, these boats were rowed through the open water, then pulled up onto the ice and propelled by sails as far as the ice lasted, then back into the churning water to row again. The men tied themselves to the boat as a precaution against falling through the soft ice.

There were no doctors across the river in Canada, just opposite Marine City, and Dr. DeGurse

was often called to attend the sick there. But he had no license to write prescriptions in Canada; so he would go over as well prepared as possible, but if he didn't have the right medication with



You won't recognize him, but Doctor DeGurse is one of the three men pictured with the sail sled-boat. He used it to cross the St. Clair river to treat Canadian patients.

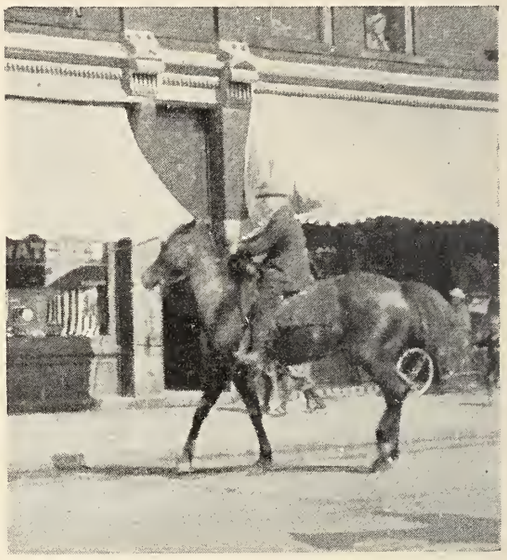
him, would bring some member of the patient's family back across the river with him, for drugs.

The entire River District was infested with typhoid fever, smallpox and diphtheria. In his first year of practice, Dr. DeGurse saw 250 cases of typhoid, and it was also in that year that he quarantined himself for three weeks with a smallpox victim because he was unable to find anyone to care for the patient. Consequently, the doctor contracted the disease himself—a mild case, he maintains. But the patient lived, dying in 1944 at the age of eighty-four. Epidemics of typhoid occurred again and again, in 1898, 1902, 1903 and 1908. The district was literally disease-ridden, and the young doctor began to study ways and means of its prevention.

His practice was interrupted, however, by the Spanish-American War, and he enlisted in 1898 in the U. S. Army Medical Corps, as a private. He was soon advanced to the rank of Chief Hospital Steward, and was sent to the Island of Puerto Rico. No major engagements were fought in this area, but the Medical Corps had to fight tropical fever and dysentery, which enemies were more virulent than the Spaniards. In attempting to save his comrades and one dear friend in particular, the doctor himself became a victim of the epidemic, and was discharged in Detroit, weighing sixty-five pounds, one-half of his normal weight.

After recovery, he returned to Marine City to resume his practice, and in 1901 married Margaret Elizabeth Newell, of Port Huron. They had four children: Edward Newell, John Louis, Thomas Edward, Jr., and Margaret Elizabeth.

In 1902, Dr. DeGurse was appointed Health Officer for Marine City, which office he retained



Fortunately, Doctor DeGurse is a fine horseman—some of his patients could be reached by no other mode of travel.

for thirty years at a varying fee, the peak being $100.00 a year. He also became Health Officer for Cottreville Township, at a salary of $50.00 a year.

In 1908, his real life battle began, when it was discovered that typhoid fever was spread through drinking water. The St. Clair River was killing off the people, and the water must be purified. After years of fighting against prejudice and ignorance, Dr. DeGurse succeeded in convincing the people that chlorine in the water wouldn't "eat out their innards." Dry chlorine was used. This helped to avert widespread epidemics, but was not completely satisfactory. The doctor felt that liquid chlorine would prove more effective.

However, the Common Council would not authorize any more new-fangled ideas. The present improvement seemed radical enough.

The Council still refused to change from dry to liquid chlorine. So the new Mayor asked for help from Colonel E. D. Rich, of the Michigan

State Health Department, requesting that a man be sent in to take over the water works. Colonel Rich told him that there was no law which enabled the Health Department to make such an appointment. Dr. DeGurse answered that he was aware of that, but he didn't think the citizens of Marine City were, so Colonel Rich sent down John M. Hepler (at present State Engineer at Lansing).

The day Mr. Hepler arrived, the Common Council held a special meeting, authorized the purchase of two tanks and equipment for the use of liquid chlorine—and fired Mr. Hepler. The doctor's psychology had proved effective—the people would much rather buy the new equipment than pay Mr. Hepler $10.00 a day for his work.



A DeGurse, M.D., "First." He is breaking ground for the water filtration plant built in 1935-36, during one of his seven terms as Mayor of Marine City.

That installation improved the case history somewhat, but there was still some typhoid in the spring and fall when storms stirred up the river, and although he had relinquished the Mayor's office (and the $50.00 a year salary attached to it), Dr. DeGurse started his fight for a filtration plant.

Over a period of nearly twenty years he kept up that battle, during which time the bond issue for the filtration plant was defeated four times in special elections. So in 1936 Dr. DeGurse ran for Mayor again, and was elected. Four days later he again called on his friend, Colonel Rich, and requested that the State Health Department start suit against Marine City for supplying unfit drinking water to its citizens. Within the week the State Police served the papers, and Dr. DeGurse called a special Council meeting to put through the bond issue for the filtration plant. The citizens authorized the bonding of $60,000, and, with Federal Aid, the doctor's dream of pure water for his people became a reality. The ground was broken in December 1935, and the filtration plant was completed in 1936. The last case of typhoid was reported in the city in 1936, and the victim was one of the engineers of the construction company that was building the plant.



Street in Marine City, Michigan, "before" and "after" building of new roads during one of Mayor DeGurse's terms in office.

When the new filtration plant was built in 1936, Dr. DeGurse insisted that the old site be abandoned and a new riverside park be purchased. Working with a colleague, Dr. A. B. Armsbury, he influenced the descendants of an old Marine City family to give the city fifty acres of land for a park site, and he personally supervised and directed the construction of a municipal playground on this site. Now, properly developed, the Ward-Cottrell Park is providing a much needed recreational outlet for the people of Marine City.

Another result of the cleanup of the water situation is the now thriving resort business up the river from Marine City to Algonac, maintained by people from Detroit and Grosse Pointe and

vicinity, who return summer after summer, and who contribute to the income of the community.

Dr.Gurse served seven more terms as Mayor of Marine City, making nine terms in all, and



A warm welcome always greets Doctor DeGurse—Michigan's foremost family physician.

was never defeated at the polls. During his administrations, every inch of pavement in Marine City was laid, a bigger and better sewage system installed, and larger and safer water mains built. He persuaded the State to replace two old unsafe bridges across the Belde River with new and beautiful modern structures designed to accommodate the heavy motor traffic of today. Two new recreational parks were developed, modern fire fighting equipment was purchased, and, as a parting gesture, he initiated the plan by which the city now furnishes water to the St. Clair River front properties for four miles on each side of Marine City, thereby stimulating the resort business. During these years he also used every connection he had, and all his weapons of persuasion, to influence the state to serve Marine City with hard-surfaced roads, and was quite successful in this undertaking.

Following the smallpox epidemic of 1896, Dr. DeGurse put on a terrific campaign, aided by his colleagues, to persuade the people to submit to vaccination. It was a crusader's job, for it was almost impossible to induce the natives to permit vaccination and inoculation "with germs" to protect them against diseases which they had not yet contracted, and which, anyhow, they had always accepted as inevitable.

In 1906 he took up the fight against diphtheria, and gave the first antitoxin injection in the Marine City area. Patient resistance was terrifically tough to crack. The doctor's campaign was tireless, and when it was discovered that unafflicted persons were carriers of the disease, he had to fight harder, the opposition became worse. The idea of "carrying" disease was something the people just couldn't grasp. The doctor's self-appointed job was so difficult that in 1919 he turned over his practice to a young associate, and became engaged by the State, St. Clair County, and the Red Cross, to put on an all-out campaign to make St. Clair County a healthy place for people to live. Unsafe wells were condemned, restaurants closed until sanitary precautions were installed, and the vaccinations against smallpox were completed. Diphtheria antitoxin was still stubbornly opposed, and the doctor was threatened with personal violence in Yale, Michigan, if he administered antitoxin to the children.

So he arranged a community indignation meeting one evening with the intent to demand his own discharge, then appeared at the meeting, accompanied by the Circuit Court recording stenographer and deputy sheriffs. When the people saw this, they knew that the doctor could not be bluffed, and would invoke the full pressure of the law to make himself heard. Instead of the mob rule anticipated, the crowd controlled itself and listened to the doctor, and with his own power of persuasion, he convinced them of the desirability of diphtheria antitoxin.

He was not so fortunate in nearby Capac, however, and his meeting there failed. Realizing that the people of Capac had to be brought to their senses by drastic means, the doctor got the high school graduation exercises and class dance prohibited by law enforcing agents. The people then realized that the health of the community was going to be protected whether they wanted it or not, and they stopped their objections, and have since become dear friends of Dr. DeGurse.

This campaign ended, Dr. DeGurse returned to private practice.

In the '20's, the advent of steel freighters practically killed the shipbuilding business in Marine City, whose yards had built only wooden ships.

The town was in danger of bankruptcy, with extreme hardship on the people. So Dr. DeGurse looked around for other means of livelihood for his people. It was largely through his efforts that Standard Products Corporation, The Detroit Gasket and Manufacturing Company, and the Motor Valve Company were induced to come into Marine City. After he had gotten them there, he didn't forget them. Shortly before the new filtration plant was installed, a heat wave caused a shortage of water pressure, and the Standard Products Company was forced to curtail production to such an extent that it planned to withdraw its plant from the town. When the doctor heard of this, he prevailed upon a hastily called citizens' committee to petition the Council to detail the fire truck to boost the water pressure, and in so doing, saved the city an industry whose weekly payroll was in excess of $7,000.00.

In all this civic activity, the doctor kept up his professional work.

He participated in the first appendectomy in St. Clair County in 1903, performed by Dr. Angus McLain of Detroit, on the kitchen table of a farmhouse.

He also assisted in one of the first major operations performed in Lambton County, Ontario, crossing the river through ice floes in the spring, with an assistant.

In 1930 he reported the third case of undulant fever in the State of Michigan.

During World War I he was surgeon on Draft Board No. 2, located in Port Huron, 20 miles away. His service was voluntary, and he was in daily attendance on his practice during this period, in the evening, late night, and early mornings, often starting his day at six in the morning and finishing at midnight or later.

In World War II, Dr. DeGurse acted as Chairman of the Appeal Board for District 11 from the time of its inception until it was dissolved by the government. During this time the Board handled over 16,000 appeals from St. Clair, Sanilac, Macomb and Wayne Counties.

He has been appointed acting Assistant Surgeon, U. S. Public Health Service, annually since 1928, for the purpose of teaching ship sanitation and first aid to students of the Lake Carriers' winter school for Ship's Officers.

In October, 1938, Dr. DeGurse was selected by his colleagues to represent them as Councilor of the Michigan State Medical Society, and has been re-elected to serve until 1952.

He was surgeon for the Detroit Railway, Port Huron to Detroit branch, for thirty years, and at present is district surgeon for the Detroit Gasket and Manufacturing Company, the Motor Valve and Manufacturing Company, the Detroit Edison Company, the Michigan Bell Telephone Company, and the U. S. Steel owned Pittsburgh Steamship Co., the operators of the largest fleet of boats on the Great Lakes.



Doctor DeGurse and Councilors of the Michigan State Medical Society, 1947.

In 1937, the Michigan State Medical Society, in co-operation with Wayne University and the University of Michigan, decided to set up postgraduate work for the County Medical Societies, establishing spring and fall sessions of four meetings each. Attendance at eight sessions over a four-year period gives the student the rating of Associate Fellow. Sixteen completed sessions—in eight years—make him a Fellow. Dr. DeGurse was one of the first to enroll. In order to complete the work for Fellowship he drove back and forth to Flint (a total distance of 186 miles). In 1940 he persuaded the director to let him establish postgraduate work at Mt. Clemens, and in the spring and fall from 1940 to 1947, these sessions had an average attendance of thirty-eight at each meeting.

Dr. DeGurse's practice has spread out from the

Pictorial illustrations by Dale Rooks.

southern tip of Horsen's Island, in a circle including New Baltimore, Michigan, through New Haven, Richmond, Memphis and north of St. Clair, a total of nearly 300 square miles, where



Doctor DeGurse at surgical operative clinic.

he has an enormous following of patients who were never denied medical treatment, if ill or injured and in need of help. Politically, his influence has covered a much wider area.

In the late '20's, a group of Detroit doctors tried to lure him away. Knowing of his genius for diagnosis, they invited him to move to Detroit and become one of their associates, with a guaranteed income (for a set period of time) far beyond any small town doctor's dreams. But Dr. DeGurse could not be tempted. The people of Marine City were his people. He could not leave them.

In 1940, a bill came up before the Congress of the United States which threatened the prosperity of the town, and again Dr. DeGurse went into action. The bill provided for more water to be taken from the Great Lakes, through the Chicago Drainage Canal, into the Mississippi. Already the Mississippi was taking 5,000 cubic feet per second. Any more would lower the water in the Lakes and contributing rivers, and appreciably reduce the tonnage which the rivers could carry.

So Dr. DeGurse sent his longtime friend, Capt. Joseph Smith, veteran skipper, down to Washington to fight the bill. It is needless to say that the bill did not pass. For Dr. DeGurse fought all his fights to win, and he always won.

The people have not been unappreciative. In 1921 the community presented him with a silver



Doctor DeGurse visiting crippled children at one of the orthopedic clinics.

loving cup half as tall as the doctor, on which is inscribed:

Presented to
HON. T. E. DeGURSE
Mayor of Marine City
as a token of love and esteem
and in grateful appreciation
of his splendid work in the
inauguration of public
improvements and pavements
in
Marine City
by his
Friends and Wellwishers
February 1st, 1921.

In 1945, the Knights of Columbus, Council 856, Marine City, presented him with a gold medal in commemoration of his 50 years' service to the community.

But his real reward is the love and trust of his people.

At seventy-four, Dr. DeGurse is still carrying on his full practice, with the exception of late night calls. His office, on the second floor of a downtown building, is a model of modern equipment, occupying five rooms which constitute a

complete clinic, with a short-wave diathermy machine, an ultraviolet ray machine, a special E.N.T. room, fully equipped. He has a virtual drugstore, too, for although the druggist is one of his best friends, large numbers of his financially unfortunate patients cannot afford drugstore prescriptions, and so the doctor furnishes the medication free. On one wall of his office hangs a sign which reads, "All office calls $2.50,"—that, including drugs!

His front windows look out upon a clean, bright little city, whose people are both healthy and employed, through his efforts. His back porch overlooks the St. Clair River, and is situated not more than seventy-five feet from the main channel of the stream. Often when he hears a boat coming along, he runs out onto the back porch with a megaphone, to shout at the Captain and the crew, for he knows them all.

To look at him, one would not dream that he is such a fighter. He is a slight, mild-mannered man, with thinning, curly white hair, and a quiet twinkle in his eyes. But there is a sharpness in those eyes, too, enough to give credence to the story (true) that he once threw a wrestler bodily out of his office for being unco-operative. And another true story that he knocked out a farmer who objected to an instrument delivery. (Dr. DeGurse laid the man flat with a punch in the jaw, continued the delivery, and when the mother and child were safe, revived the father.) A few minutes' talk with him, and the visitor knows how it was that Dr. DeGurse could clean up a whole area of 300 square miles, against the wishes of its inhabitants.

Left alone in 1944 by a tragic automobile accident which killed his wife, Dr. DeGurse lives by himself in his big house on Main Street, but his neighbors and friends watch over him carefully, fearful of both his loneliness and his health. Often, patients call his nearest neighbor before they call the doctor, asking, "Is there a light in the Doctor's house? Is he still up?" And his friends accompany him on long or night trips, to relieve him of driving.

All through the years, Dr. DeGurse has been friend and adviser to his people, as well as physician. They come to him when they are ill in spirit, just to talk things over with him. And as often as not, when he has treated them for both physical and spiritual ailments, they will tell him, "I don't know whether your medicine helped or not, Doctor DeGurse. But *you* did."

Presentation of Michigan's "Foremost Family Physician" Award

T. E. DeGurse, M.D., Marine City, was given the "Foremost Family Physician" Award by the Michigan State Medical Society on the occasion of the Michigan Postgraduate Clinical Institute in



Left to right: P. L. Ledwidge, M.D., Detroit, MSMS President, and T. E. DeGurse, M.D., Marine City, recipient of the Award made in Detroit on March 11, 1948.

Detroit on March 11, 1948. The impressive ceremony was made dramatic by the following sincere words of P. L. Ledwidge, M.D., President of the Michigan State Medical Society, a long-time friend of Dr. DeGurse, who stated:

"There has been considerable evidence in recent months that the general practitioner is again coming into his own in Michigan such as the creation of Sections on General Practice by the Michigan State Medical Society and by the American Medical Association; The organization of the American Academy of General Practice; the special postgraduate training courses in general practice being given by the University of Michigan Medical School and others with financial aid from the Kellogg Foundation; and the help offered by the Michigan Foundation for Medical and Health Education to undergraduate medical students preparing to practice in rural areas, all point in this direction.

"Presumably to stimulate interest in an organization of the general practice group, the American Medical Association last year offered a special award to the country's most outstanding general practitioner, and invited the various states to make nominations for this award.

"Michigan nominated Dr. Thomas E. DeGurse of Marine City. It is obvious that with nominations from forty-eight states, not every candidate could win; nor can we complain that the American Medical Association made its award to a very worthy candidate from another state. We can, however, do something for Dr. DeGurse that we believe will mean more to him than winning the American Medical Association award would have meant. Knowing Dr. DeGurse as we do, we feel certain he would prefer an award from his friends and colleagues in the Michigan State Medical Society to an award from strangers outside of Michigan.

"With your permission, I shall read some excerpts from the material that was prepared for the American Medical Association award competition:

> " 'Thomas Edward DeGurse was born on July 18, 1873, one of ten children. His people were farmers, and he learned hard work when only a boy. After his mother's death and his father's remarriage, he left home at the age of nine and went to live with an elder sister on a farm, doing chores to earn his way. At fourteen he hired out as a hired-man, farming in summer and lumbering in the woods in winter. At sixteen he left the farm and joined a brother who was a Civil Engineer for the City of Windsor. He worked with his brother as a chainman until he had earned and saved enough money to attend Assumption College and then the Detroit College of Medicine (now Wayne University).
>
> " 'In spite of financial hardships, Thomas DeGurse received his M.D., at the age of twenty-three, and opened an office in Marine City in 1895 for the general practice of medicine.
>
> " 'For more than fifty years Dr. T. E. DeGurse has combined a fulltime general practice with a record of public service which, in itself, has been a complete career, either one of which could have constituted the life work of any lesser man, with honor. His activities for civic betterment through health improvement have been of inestimable value to his community, and rank him not only one of the great men of his State, but of the whole country.
>
> " 'In his little town of Marine City, Michigan, he has fought not only disease and poverty, but prejudice, ignorance, city councils, and, in one instance, the Congress of the United States, to make his community, which he has served as Health Officer for thirty-five years, a better place for his people to live in. And, unlike so many other crusaders, he has lived to see the results of his work, in a whole area free of typhoid, small pox and diphtheria, in a thriving town supported by industries which he himself brought in, serviced by good roads which were built during his nine terms as Mayor of the city, peopled by four generations of patients who respect, trust, and adore him. He is more than a public servant and more than a general practitioner. He is both.'

"This material was supported by testimonial letters from nineteen social and civic organizations in Marine City. Time does not permit reading them.

"We are always talking about 'firsts' for Michigan. May I mention a few 'firsts' for Dr. DeGurse? He made his first obstetrical delivery on a pile of straw in a livery stable for a poor girl who had crawled in there because she had no place else to go. During his first year in practice he saw 250 cases of typhoid fever, and was the first in his community to advocate a pure water supply after science had demonstrated that typhoid is spread by polluted water. He gave the first dose of diphtheria antitoxin to be given in the Marine City area. He assisted at the first appendectomy done in St. Clair County. He has yet to be guilty of his first unethical or unprofessional act.

"So, tonight we honor one of this country's most distinguished general practitioners; one of our own members who has rendered kindly and efficient medical care to four generations of people over a period of fifty-three years; an outstanding, self-sacrificing public-spirited citizen; a fine physician; a man of sterling worth and saintly character.

"Dr. DeGurse, it is a very great pleasure for me to present to you on behalf of the members of the Michigan State Medical Society, in recognition of your splendid service to humanity, this scroll as well as this book, a short biography of your life, a beautiful book filled with beautiful thoughts.

"With these tokens go the respect and the love of every Doctor of Medicine in Michigan who has had the happy privilege of knowing you.

"May God bless you and keep you for many years to come, to care for your four generations of patients and to set an example for the rest of us in the proper practice of the Art and the Science of Medicine."

Response of Dr. DeGurse

The modesty of the great but humble recipient of the Foremost Family Physician Award is best exemplified by the response of Dr. DeGurse, who said simply and briefly:

"Thank you for the honor you have conferred on me. I hope I deserve it."

Fan Mail to the "Foremost Family Physician"

Since being presented with Michigan's Foremost Family Physician award at the Michigan Postgraduate Clinical Institute in Detroit on March 11, T. E. DeGurse, M.D., Marine City, is beginning to realize what it means to receive fan mail. To date he has been flooded with over 250 letters and telegrams from friends and well-wishers throughout the United States. For example:

Government

Governor Kim Sigler: "Michigan is proud that you have been given the title of 'Michigan's Foremost Family Physician.' For myself and on behalf of the people of our Commonwealth whom your profession so well serves, I send my congratulations and wish for you many more years of devoted service."

Eugene F. Black, Attorney General: "Please accept

(Continued on Page 544)

PRELIMINARY OUTLINE OF 1948 GENERAL ASSEMBLY SPEAKERS

83rd Annual Session, Michigan State Medical Society

Detroit, September, 1948

Time	Wednesday September 22	Thursday September 23	Friday September 24
A.M. 8:30	Registration. Exhibits Open	Registration. Exhibits Open	Registration. Exhibits Open
9:00	*Surgery* F. H. Lahey, M.D. Boston	*Gynecology* R. W. TeLinde, M.D. Baltimore	*Medicine* T. G. Randolph, M.D. Chicago
9:30	*Medicine* I. S. Wright, M.D. New York City	*Otolaryngology* T. C. Galloway, M.D. Evanston, Illinois	*Syphilology* D. M. Pillsbury, M.D. Philadelphia
10:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:00	*Anesthesia* S. C. Cullen, M.D. Iowa City, Iowa	*Pediatrics* R. L. J. Kennedy, M.D. Rochester, Minnesota	*General Practice* W. J. Reich, M.D. Chicago
11:30	*Dermatology* A. R. Woodburne, M.D. Denver, Colorado	*Public Health & Preventive Medicine* Haven Emerson, M.D. New York City	*Nervous & Mental Diseases* C. C. Burlingame, M.D. Hartford, Connecticut
P.M. 12:00	4 Section Meetings *Dermatology* A. R. Woodburne, M.D. Denver, Colorado *Anesthesia* S. C. Cullen, M.D. Iowa City, Iowa *Urology* J. E. Dees, M.D. Durham, North Carolina *Gynecology-Obstetrics* M. E. Davis, M.D. Chicago	5 Section Meetings *Pediatrics* R. L. J. Kennedy, M.D. Rochester, Minnesota *Surgery* F. A. Coller, M.D. Ann Arbor *Otolaryngology* T. C. Galloway, M.D. Evanston, Illinois *Ophthalmology* F. H. Adler, M.D. Philadelphia *Public Health & Preventive Medicine* Haven Emerson, M.D. New York City	4 Section Meetings *Pathology* S. P. Reimann, M.D. Philadelphia *Medicine* H. J. Kullman, M.D. Dearborn, Michigan *General Practice* W. J. Reich, M.D. Chicago *Nervous & Mental Diseases* Speaker to be chosen.
1:30	*Pediatrics* A. L. Gesell, M.D. New Haven, Connecticut	*Medicine* J. B. Barnwell, M.D. Washington, D. C.	*Surgery* Alexander Brunschwig, M.D. New York City
2:00	*Urology* J. E. Dees, M.D. Durham, North Carolina	*Surgery* L. H. Dragstedt, M.D. Chicago	*Pediatrics* Speaker to be chosen
2:30	*Obstetrics* M. E. Davis, M.D. Chicago	*Ophthalmology* F. H. Adler, M.D. Philadelphia	*Pathology* S. P. Reimann, M.D. Philadelphia
3:00	Intermission to View Exhibits	Intermission to View Exhibits	Final Intermission to View Exhibits
4:00	*General Practice* Philip Thorek, M.D. Chicago	*Obstetrics* E. G. Waters, M.D. Jersey City, N. J.	*Surgery* W. H. Cole, M.D. Chicago
4:30	*Surgery* Waltman Walters, M.D. Rochester, Minnesota	*Surgery* Speaker to be chosen	*Medicine* W. L. Palmer, M.D. Chicago
5:00	Discussion Conferences	Discussion Conferences	Discussion Conferences
8:30	Officers Night Biddle Oration	10:00 P.M. State Society Night (Entertainment)	END OF ANNUAL SESSION

(Continued from Page 542)

my heartiest congratulations. You surely deserve the honors given you by the medical profession and I am glad to see that recognition has finally been given your genuine service to our people. Being one of your first baby jobs, and having received help from you ever since, should know that the medics have not overstated their tribute."

Harry J. Phillips, State Representative: "Congratulations on your well-deserved recognition."

Patients

"As I told you one day in your office, just to hear you laugh made one feel better even before you had a chance to prescribe any pills." . . . "I know of no greater heritage you can leave to your community as well as to all of us who have been privileged to know you than your shining example of unselfish service to your fellow man." . . . "Have known you were the best doctor in the world for forty years. *(Signed)* One of your babies." . . . "Your diagnostic skill saved Ethel Wright's life. Later she married me. Accept our gratitude and congratulations." . . . "Aside from wonderful personal memories, you surely saved our Ethelmae and Chet, and so have given me years full of happiness."

Doctors of Medicine

"I have always been a great admirer of yours, and I have always thought of you as a representative of the highest type of medicine in all its forms. The years have only served to confirm that belief." . . . "The many little and big things which you have done so unselfishly have endeared you to the hearts of your fellow physicians. I shall never forget that when I opened my practice in a small town, to which I was utterly strange, you alone had the thoughtfulness to come and lend the encouragement which I needed."

These are extracts from but a few of the letters which Dr. DeGurse has received. Their sentiments were well summed up in a letter from a friend in St. Clair, Michigan:

"You have given a lifetime to your work, and have brought so much happiness into the lives of everyone with whom you came in contact. We feel it to be a great privilege to have the opportunity of expressing the reverence we feel for you. Your kindness has meant so much to so many people, always."

STUDY OF HEALTH AGENCIES

The Kent County Medical Society has completed a study of the various health agencies operating in the county. According to their report, "The multiplicity of health agencies operating in this community, especially in regard to the care of indigent patients, shows complete lack of co-ordination. The county fails to make adequate use of available medical talent," the report continued, "and also fails to meet the ideas of a good overall health program." The report suggested steps which might be taken to improve health conditions in the county.

The Council on Medical Care of the AMA commended the Kent County Society on this study, stating that a study of this type is of great value in planning an effective county medical plan.

DETROIT PHYSIOLOGICAL SOCIETY

(Continued from Page 530)

glycosuria of insulin-treated depancreatized dogs. Several antagonists of vitamins have been tested by one or more of these methods, the diet in each instance being free of the corresponding vitamin or containing subminimal amounts of it.

Results for the niacin analogue, pyridine-3-sulfonic acid, which was given in doses of 0.5 g. per animal per day, were negative by all of the above criteria. In these experiments the diet contained over 36 per cent of vitamin-free casein. Other experimenters using niacin-deficient diets containing 18 per cent of casein and 72 per cent of yellow corn have reported fatal results with 0.2 g. doses of pyridine-3-sulfonic acid in the dog. It is assumed that the high casein content of our diet led to greater production of niacin from tryptophane, thus protecting the animals. That such synthesis of niacin is not very extensive in the dog was indicated by two findings. Puppies increased their rate of gain in weight when niacin was added to the niacin-free high casein diet, and one of two adult dogs developed blacktongue after receiving this diet for fifty-one days, during the last thirty of which pyridine-3-sulfonic acid was given daily in the stated dose.

Desoxypyridoxine (2, 4-dimethyl, 3-hydroxy, 5-hydroxymethyl pyridine) in doses of 0.5 g. and 1.0 g. daily, and the sodium salt of pantoyl taurine, in doses of 1.0 and 2.0 g. daily, were without notable affect upon the nitrogen balance or glycosuria of an insulin-treated depancreatized dog receiving a diet containing subminimal amounts of the vitamin corresponding to the analogue used in a given experiment. Elevation of blood sugar was observed with both antimetabolites, but was transient. Negative results with the sodium salt of pantoyl taurine were of interest since feeding pantoyl-tauryl-chloroanilide (1 g. daily) had been followed by complete refusal of food and other untoward effects in the same animal.

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407 AT WEST SIDE DINNER

The West Side Medical Society (Detroit) broke all attendance records at its annual meeting of April 14, held in the Northwest American Legion Building. Four hundred and seven were present for the dinner and dance arranged in honor of out-going President L. J. Gariepy, M.D., Detroit, who received an engraved plaque for his service to the West Side Medical Society and a rising vote of thanks for his administration of the affairs of this branch of the Wayne County Medical Society during the past twelve months.

"...pressure of the gravid uterus mechanically interferes..."

in pregnancy

"Constipation is the rule. The pressure of the gravid uterus mechanically interferes with the function of the small intestine and colon per se and also renders the act of defecation less efficient by its effect on the diaphragm, abdominal muscles and levator ani."

—*Bockus, H. L.: Gastro-Enterology, Philadelphia, W. B. Saunders Company, 1946, vol. 3, p. 999.*

"Smoothage" for Management of Constipation in Pregnancy

Management of bowel evacuation without the use of irritant laxatives is accomplished with the gentle, nonirritating action of Metamucil—"smoothage."

By providing soft, plastic, water-retaining bulk, Metamucil promotes normal, easy peristaltic movement—the desired action in pregnancy.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Michigan's Department of Health

G. D. Cummings, M.D., Acting Commissioner

NAMED ACTING COMMISSIONER

G. D. Cummings, M.D., became Acting Commissioner of the Michigan Department of Health on March 17, 1948, upon appointment by Governor Kim Sigler.

Dr. Cummings succeeds Dr. J. K. Altland, who resigned and has resumed his former duties as Director of the Bureau of Local Health Services.

Dr. Cummings has been with the Laboratories of the Michigan Department of Health for the past twenty-two years. He came to the Department as a junior bacteriologist in 1926 soon after his graduation from Massachusetts Institute of Technology as a sanitary engineer. He was promoted successively to Senior Bacteriologist, Assistant Director of the Bureau of Laboratories and Associate Director of the Bureau of Laboratories. He became Director of the Bureau of Laboratories, following the death of Dr. C. C. Young, in 1944.

Dr. Cummings has his Doctor of Medicine degree from Wayne University and his Doctor of Philosophy degree from the University of Michigan.

ON INTERNATIONAL COMMITTEE

Dr. William Wesley Ferguson, Co-ordinating Bacteriologist and Chairman of the Research Committee of the Michigan Department of Health, has been appointed to the Enterobacteriaceae Subcommittee of the Nomenclature Committee of the International Association of Microbiologists, according to announcement from Washington.

Dr. Ferguson is one of four Americans honored with membership on the international committee organized for the evaluation and study of causes of dysentery.

When notified, Dr. Ferguson was aboard ship en route to Copenhagen, Denmark, where he will study the classification af caliform and paracolon organisms in Danish Serum Institute. This study is being financed by the Commonwealth Fund.

Dr. Ferguson, forty-one, a native of Bedford, Indiana, whose present home is in Lansing, has his Bachelor of Science and Master of Science degrees from Purdue University, and his Doctor of Philosophy degree from Michigan State College. He has been a member of the staff of the Michigan Department of Health Laboratories since July 1, 1934.

CONSIDER CANCER REPORTING

The National Cancer Institute of the United States Public Health Service has announced a grant of $25,-160 to the Michigan Department of Health to conduct a study to determine the best methods of obtaining cancer morbidity information.

The study will be conducted on a statewide basis and will follow the pattern of the nine-county pilot study financed by the federal government in the state last year. It will be in charge of the Bureau of Disease Control of the Department.

PRESIDENT-ELECT

K. E. Markuson, M.D., Director of the Bureau of Industrial Health, Michigan Department of Health, was named president-elect of the American Conference of Governmental Industrial Hygienists at its annual meeting in Boston. Previously he had been named president-elect of the Michigan Association of Industrial Physicians and Surgeons.

STUDY IN DEPARTMENT

Kim Chang, M.D., Chief of the Hospital Services Section, Medical Services Bureau, Department of Health and Welfare, in the Military Government of Korea, who is spending a year studying in this country, visited the Michigan Department of Health, March 23-26.

Dr. C. P. Mom, Director, and J. J. Hopmans, Chief Engineer and Chemist, of the Institute of Sewage Purification, The Hague, Netherlands, visited the Department April 7.

Charles M. Leach, M.D., and Oliver R. McCoy, M.D., members of the staff of the International Division of the Rockefeller Foundation, visited the Department April 8.

AIDS NURSING PROGRAM

The W. K. Kellogg Foundation has announced a grant of $10,000 to the Michigan Nursing Center Association to assist the organization in carrying out the program it has planned for the next year.

The Nursing Center Association is an organization which grew out of a survey on Nursing Resources and Needs in Michigan financed by the Foundation. The purpose of the organization, which may set a pattern for other states and the nation to follow, is to coordinate all professional and practical nursing activities toward relief of the critical nursing shortage and other nursing problems.

FOR MEASLES CARE

During the first three months of 1948, the American Red Cross gave the Michigan Department of Health 15,000 vials of gamma globulin to be distributed among physicians of the state for necessary modification or prevention of measles.

EQUIP NOVEL HEARING TEST UNIT

To bring full benefit of the Michigan Department of Health's Hearing Conservation Program to school children in rural areas of the state, the Department has

(Continued on Page 548)

For surface infections...



New and Nonofficial Remedies · 1947 · states: "NITROFURAZONE.—Furacin... possessing bacteriostatic and bactericidal properties . . . effective in vitro and in vivo against a variety of gram negative and gram positive bacteria . . . is useful for topical application in the prophylaxis and treatment of superficial mixed infections common to contaminated wounds, burns, ulceration and certain diseases of the skin . . . Variant bacterial strains showing induced resistance to sulfathiazole, penicillin or streptomycin are as susceptible to nitrofurazone as their parent strains . . ." Furacin N.N.R. is available in the form of Furacin Soluble Dressing containing 0.2 per cent Furacin. This preparation is indicated for topical application *in the prophylaxis and treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.* EATON LABORATORIES, INC., NORWICH, N. Y., — TORONTO, CANADA



The Council Accepted

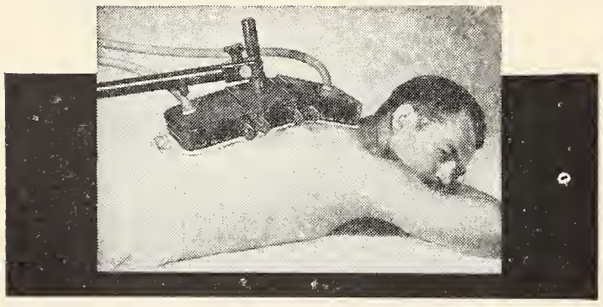
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THE G. A. INGRAM COMPANY

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HEARING TEST UNIT

(Continued from Page 546)

equipped a mobile hearing testing trailer which is ready to go into the field.

The 21-foot trailer, first equipment of its kind ever built, has two rooms, one for controls and the other, soundproofed for testing. The soundproofed room contains electrical acoustic equipment making possible a number of tests devised by the Army and Navy for use in their hospitals with deafened servicemen to determine the extent of their hearing handicap. It can also be used for the selection and evaluation of hearing aids.

The trailer will be used in connection with the Hearing Conservation Program to permit more detailed studies of the needs of hard-of-hearing children. It affords facilities for use in rural areas which have previously been available only in large metropolitan areas.

The mobile unit was made in Lansing according to specifications planned by the acoustic engineers of the Bell Telephone Laboratories in New York, and the Psycho-Acoustic Laboratories of Harvard University.

More than 250,000 Michigan children have been tested for hearing loss under the Hearing Conservation Program since it was begun in 1942. The program in the state is carried on by Courtney Osborn and Raymond Cromer, hearing consultants of the Michigan Department of Health.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*March 1948*	*March 1947*
Diphtheria	17	22
Gonorrhea	791	884
Lobar pneumonia	86	166
Measles	8014	263
Meningococcic meningitis	13	14
Pertussis	430	1003
Poliomyelitis	3	2
Scarlet fever	804	769
Syphilis	1102	1412
Tuberculosis	441	614
Typhoid fever	1	4
Undulant fever	26	17
Smallpox	0	0

Suspect CANCER at any age.

. . .

A stitch in time saves nine—especially the stitches in an early radical mastectomy incision.

. . .

If you think a tumor is benign, PROVE IT.

. . .

Red is the color of Communism. So is the hemorrhage in early cancer. Both menace our American life. Let's do something about it.

. . .

CANCER spelled backwards means nothing. So does late treatment.

. . .

The word "facetious" is the only word in the English language that contains all the vowels in their alphabetical order. It has no place in your replies to a patient who comes to you fearful of a cancer.



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Another symbol of safety through rigid control is the blue and white symbol of Rexall. About 10,000 conveniently located, independent drug stores display the familiar Rexall sign. It is your assurance of reliable pharmaceuticals and superior pharmacal skill in their compounding.

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Woman's Auxiliary

HEALTH PROGRAM

March was specifically designated as Health Month by Mrs. Grover Amos, president of the Woman's Auxiliary to the Michigan Medical Society, but the health program will be a continuing effort. It did not end on the last day of March. The designation of the month is only the beginning. The Auxiliary is endeavoring to project the policies of the national auxiliary by planning a Health Day in every city, town and hamlet. To help us extend our efforts, the Bureau of Health Education of the American Medical Association assembled packets of material which were sent to each state public relations chairman giving information and data on all phases of health education.

All communities offer many opportunities for leadership in health projects. Throughout the year we have health drives: such as cancer, heart disease, crippled-child relief, rheumatic fever, and tuberculosis.

The following is a concrete example in which an auxiliary member directed and provided forceful leadership in a health project. Mrs. D. M. Kane was presented with a scroll and orchid by the St. Joseph County Medical Society in recognition of her work as commander of the St. Joseph County Organization of the American Cancer Society the last two years. During the time Mrs. Kane has headed the local cancer society drive, St. Joseph County has led Michigan in per capita contributions. The drive netted $9,008.53 this year and $8,211.55 last year; goal for both years was $2,076.62. Fifty per cent of the funds remain in the county, and the other half is forwarded to the state organization; 10 per cent of the state's amount is used for administrative purposes and 40 per cent for research. Mrs. Kane was the first lay person to be honored by a medical group in Michigan for work in the cancer drive.

Each county auxiliary participated for the sixth consecutive year in the tuberculosis project. About 35,000 students in eighty-one schools entered the event this year. Local audiences totaling more than 15,000 heard about tuberculosis in community programs.

Every member of the Woman's Auxiliary should know something about the Voluntary Prepayment Medical Care plan movement. Prepayment is a big problem and a full explanation would require far more pages than the average auxiliary member would wish to read. To solve this problem the Saginaw Auxiliary presented Dr. John S. De Tar and Mr. Hugh Brenneman at an open meeting. One hundred and fifty invitations were sent out and personal telephone contacts made to all organizations in the community. As a result, the speakers gave authentic and sanctioned information in a stimulating manner to a large audience.

Flint Auxiliary chose to present Dr. George Hays, Public Health Officer, for a Public Relations meeting. Dr. Hays spoke on "Rural Health Programs."

A lot of credit is due Bay County Auxiliary for sponsoring the Easter Seal Sale for Crippled Children again this year.

Every county auxiliary is concentrating on some public health project this month, but up-to-date reports have not been received of the accomplishments.

In a democracy, extensive measures to protect and promote public health are seldom if ever possible without appreciable support and understanding. It is the intention of the State Auxiliary that public health programs and projects for laity, create harmonious understanding and appreciation of one another.

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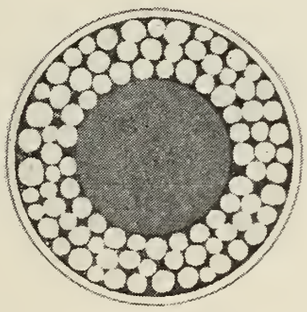
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LABORATORY TEST

Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

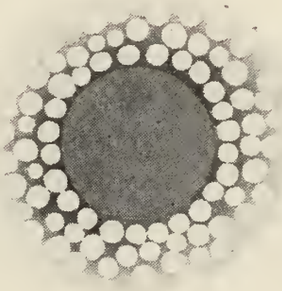


Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.

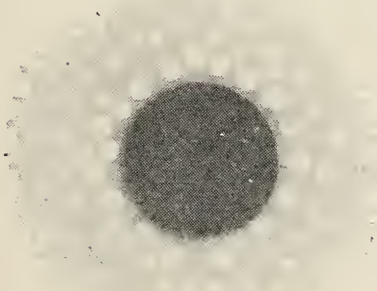
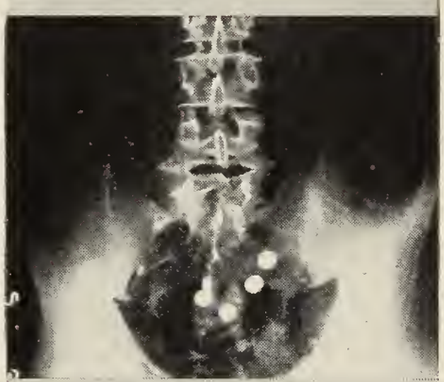


Fig. 3 — Complete disintegration.

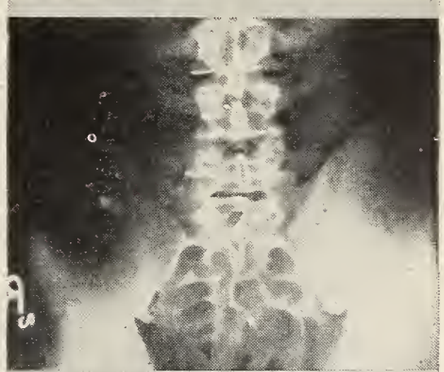
CLINICAL CONFIRMATION



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Communication

"The Policy of Excess"

To the Editor:

About a year ago I published an article with the above title (JMSMS, 46:682, (June) 1947, in which I stated my belief that the Military Services owe the country an explanation of their demands for medical personnel 500 per cent in excess of those of the civilian public.

Such a public explanation has not been forthcoming, but after extended correspondence with Admiral C. A. Swanson, Surgeon-general of the Navy, I have learned some of the background of this policy. In view of the fact that both Army and Navy are beginning to contact Reserve Medical Officers with regard to the formation of Reserve Ready Units, I believe some of this information will be of interest.

Regarding the basic disagreement, Admiral Swanson writes: "To intelligently appraise your allegation that the Service claims are 500 per cent in excess of Civilian needs, two considerations must be taken into account. First, unless the position is assumed that the civilian need is regarded as being satisfied, the figure quoted by you is not necessarily 500 per cent in excess of it."

Such a position was distinctly not taken. What was pointed out, was that the civilian needs were largely ignored or given little consideration in the rush to bring the Service Medical Corps as near to theoretical strength as possible, resulting during the war in an excess of 800 per cent over the civilian Medical Services. While it would be theoretically desirable to increase the number of physicians available for civilian service, one must take the realistic position that the supply is strictly limited, and that an appraisal must be made on actual factors, rather than theoretical desiderata.

It has been estimated that by 1960 there will be a deficit of about 30,000 doctors in this country, which means that the services should reduce their demands as time goes on, but no indication of such a reduction has as yet been evident.

Admiral Swanson continues: "Second, it is essential that the judge of whether or not there is an inequity, and if so, how great an inequity, must know the size of the order service doctors may be required to fill." He then goes on to state that, in addition to the active strength of the Navy and Marine Corps, the Navy is responsible for upwards of 1,500,000 people in the following categories:

Retired Officers and Men of Navy	29,522
Retired Officers and Men of Marine Corps	2,960
Fleet Naval Reserve, inactive (9-30-47)	13,681
Fleet Marine Corps Reserve, inactive (9-30-47)	750
Dependents of Active Personnel, Navy and Marine Corps	524,988
Dependents of Navy Retired	26,140
Dependents of Marine Corps Retired	2,664
Dependents of Inactive Fleet Naval Reserve	12,313
Dependents of Inactive Fleet Marine Corps	675
Natives in Western Pacific Islands	101,000
Civilian Employes of Navy	341,382
VA patients afforded care	181,837
Members of Congress	531
Outpatient treatment to VA Beneficiaries	123,672
Inoculations, et cetera, for State, Treasury and other Departments	23,564
Diplomatic and Consular Examinations	1,165
Miscellaneous treatments, et cetera	148,400
Total	1,535,244

I shall not attempt to break this down and discuss each category, but in general, it is my conclusion that this is socialized medicine, pure and simple. The Congress has not yet passed the Murray-Wagner-Dingell bill, but here is a department of the government, which not only at the present time, but for some years back, has been practicing the principles of this bill on a sub-rosa basis, using as a reason for its demands the "needs of the service." It is a rather interesting coincidence in view of the 500 per cent excess in demand for Medical Personnel, that the civilian group for which the Navy feels itself responsible exceeds the Service Personnel group by about 500 per cent.

Gentlemen, this is it. In a short time, if the war psychology progresses, every young physician will be pressured into the Reserve, and later into active duty, on the premise that he is needed for service personnel. It is obvious from the above that a good percentage of these men will treat, not servicemen, but civilians. In other words, the services will force on these men a relocation of their practices, at a small salary. During the last war I objected to being forced to treat civilians in urban centers, but obviously there was no recourse. If the government offers free medical service to 1.5 million civilians through the Navy, it would not be a far cry to ask that all civilians be included. It seems to me that it is time this subterfuge is brought to the attention of the public, and that the real reason for the excessive demand for medical personnel be clearly understood.

R. Wallace Teed, M.D.
Ann Arbor, Michigan

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In Memoriam

ALBERT STEWART BARR, M.D., Ann Arbor, Michigan. Born November 18, 1882, in Grand Island, Nebraska. Graduated from the University of Michigan Medical School in 1909. Dr. Barr took postgraduate work in New York and Boston. He served as a Captain in the Medical Corps in World War I, and was on the University of Michigan Hospital Staff from 1919 to 1922. He was a member of the Michigan Triological Society, Washtenaw County Medical Society, American Medical Association, Michigan State Medical Society, Detroit Opthalmological Society, American Academy of Opthalmology and Otolaryngology and a diplomate of the American Board of Opthalmology. He was a former member of Sigma Alpha Epsilon fraternity and Phi Rho Sigma Medical Society. Dr. Barr died on April 27, 1948, in Ann Arbor, Michigan, at the age of sixty-five.

JOHN T. BIRD, M.D., Drayton Plains, Michigan. Born March 2, 1872, in Springfield Township. Attended Holly High School; graduated from Detroit College of Medicine in 1898. He was a former member of the Oakland County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. Bird served as the house physician at the Ionia Reformatory, was in private practice in Clarkston, and was county physician at Pontiac, Michigan, for eighteen years. Dr. Bird died on March 20, 1948, in Pontiac, Michigan, at the age of seventy-six.

ALPHONSE MIDDLETON CRAWFORD, M.D., Romeo, Michigan. Born September 18, 1898 in Boissevain, Manitoba. Graduate of McGill University Medical School, Montreal, 1924. Dr. Crawford took special training in chest work at the Metropolitan Life Insurance Company Sanitarium at Mt. McGregor, New York. He served as an officer in the Royal Canadian Air Force in World War I, and was president of the Macomb County Medical Society for 1948. Dr. Crawford was also a member of the American Medical Association, Michigan State Medical Society and McGill Graduates Association. For the past ten years Dr. Crawford had specialized in chest cases with offices in Mt. Clemens and Detroit. He died on March 25, 1948, in Mt. Clemens, Michigan, at the age of forty-nine.

WILLIS L. DIXON, M.D., Grand Rapids, Michigan. Born 1890 in Dodge City, Kansas. Studied Pharmacy at Ferris Institute and graduated from Loyola University School of Medicine in 1916. Served as a Lieutenant in the Medical Corps in World War I. Dr. Dixon was President of the Kent County Medical Society in 1944. He was a member of the Kent County Medical Society, American Medical Association, Michigan State Medical Society and the American Society of Anesthesia. He was on the staff of the St. Mary's Hospital and was a well known pediatrician. Dr. Dixon died on March 12, 1948, in Corbin, Kentucky, at the age of fifty-eight.

JAMES ALBERT PAUL DUNCAN, M.D., Lansing, Michigan. Born in 1879. Graduated from Grand Rapids Medical College in 1906. He was a former member of the American Medical Association and the Michigan State Medical Society. Dr. Duncan died on April 11, 1948, in Lansing, Michigan, at the age of sixty-eight years.

HAROLD C. FREDRICKSON, M.D., Buchanan, Michigan. Born December 2, 1886, in South Bend, Indiana. Attended the University of Michigan and in 1918 graduated from the Hahnemann Medical College and Hospital in Chicago. Dr. Fredrickson practiced in Chicago until 1934 when he moved to Buchanan. He was a member of the Chicago Chapter of Pi Epsilon Rho, and a former member of the Berrien County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. Fredrickson died on April 19, 1948, in Buchanan, Michigan, at the age of sixty-one.

WILLIAM KERR, M.D., Bay City, Michigan. Born January 25, 1866, in Chatham, Ontario. Graduated from the Detroit College of Medicine (Now Wayne University) in 1894. Dr. Kerr was a member of the Michigan State Medical Society "50-year club." He was a former President of Bay County Medical Society and was elected Emeritus Member of the Michigan State Medical Society in 1944. Dr. Kerr was a member of the Bay County Medical Society, American Medical Association, and the Michigan State Medical Society. He was known as the father of the Junior Red Cross. Dr. Kerr died on March 25, 1948, in Bay City, Michigan, at the age of eighty-two.

FRANK PETRIE MABEE, M.D., Detroit, Michigan. Born in 1881. Received medical education at Wayne University College of Medicine, graduating with Class of 1919. Member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Mabee expired February 10, 1948, at Detroit, Michigan, at the age of sixty-six years, and is survived by wife, Elsie, and a brother, James.

WILLIAM B. NEWTON, M.D., Alpena, Michigan. Born 1881. Graduate of Chicago College of Medicine and Surgery in 1911. Was a member of the Alpena County Medical Society, American Medical Association, Michigan State Medical Society, American Board of Ophthalmology and American Board of Otolaryngology. Dr. Newton served as President of the Alpena County Medical Society in 1928 and 1934 and as Secretary of the County Medical Society in 1927 and 1929 through 1933. Dr. Newton died April 19, 1948, in Alpena, Michigan, at the age of sixty-seven years.

DAVID COWELL PIERPONT, M.D., Newport, Michigan. Born November 29, 1878, in Milwaukee, Wisconsin. Graduated from the University of Wisconsin in 1899 and the Columbia University College of Physicians and Surgeons in 1903. Dr. Pierpoint took postgraduate work in Vienna. He was a member of the Gogebic County Medical Society, American Medical Association, and the Michigan State Medical Society. Dr. Pierpoint died on April 15, 1948, in Ironwood, Michigan, at the age of sixty-nine.

Homewood Sanitarium



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Be sure to renew your Federal and State Narcotic licenses on or before July 1, 1948.

* * *

Wilfrid Haughey, M.D., Battle Creek, editor JMSMS, addressed the Allegan County Medical Society on March 2 on the subject "Political Medicine."

* * *

Bruce C. Lockwood, M.D., Detroit, is author of an original article, "Anomalies of the Gall Bladder," which appeared in JAMA of March 6.

* * *

Joseph G. Molner, M.D., Karl F. Meyer, M.D., Detroit, are authors of an original article, "Leptospiral Infections" which appeared in *JAMA* of March 20.

* * *

The Cover.—The pen sketch of T. E. DeGurse, M.D., and the accompanying art work on the cover of JMSMS were executed by John G. Laetz of Lansing.

* * *

The Better Business Bureau of Philadelphia recently issued a warning to be on guard for any sweepstakes tickets, supposedly for the benefit of cancer research, which may be offered you.

* * *

A Socializing Pattern?—Our editorial of that title in the January, 1948 number was copied entirely in the February, 1948 number of the *Delaware State Medical Journal,* page 34. Thanks.

* * *

AMA Representatives Visit President Truman.—On Friday, March 12, E. L. Henderson, M.D., R. L. Sensenich, M.D., and G. F. Lull, M.D., visited the President, by invitation, to discuss health matters.

* * *

The National Gastroenterological Association will hold its 13th scientific session at the Hotel Pennsylvania, New York City, June 7-10, 1948. For copy of program, write the Secretary, 1819 Broadway, New York 23, N. Y.

* * *

The American Physiotherapy Association announces its annual conference to be held at the LaSalle Hotel, Chicago, Illinois, May 23-26, 1948. For program, write the Association in care of Dana Jones, 122 S. Michigan, Chicago 3, Illinois.

ROSTER NUMBER

All members who have paid their 1948 dues by June 1 will be listed in the July number of the JOURNAL MSMS.

To assure publication of your name in the MSMS Roster, send a check today for 1948 medical society dues to your county society secretary—if this has not already been done.

"The foundations of medical practices are crumbling because too few of us remember that the bulwark of a profession is the service it renders."—Day Time Specialisms, *Genesee County Medical Society Bulletin,* March 16, 1948.

* * *

The Michigan Association of Industrial Physicians and Surgeons officers for 1948 are: E. A. Irvin, M.D., Detroit, President; K. E. Markuson, M.D., East Lansing, president-elect; J. L. Zemens, M.D., Detroit, secretary-treasurer.

* * *

Hospital Construction.—As of March 19, USPHS had approved 181 initial and completed applications, aggregating $84,640,555 for hospital construction under the Hill-Burton Act.

* * *

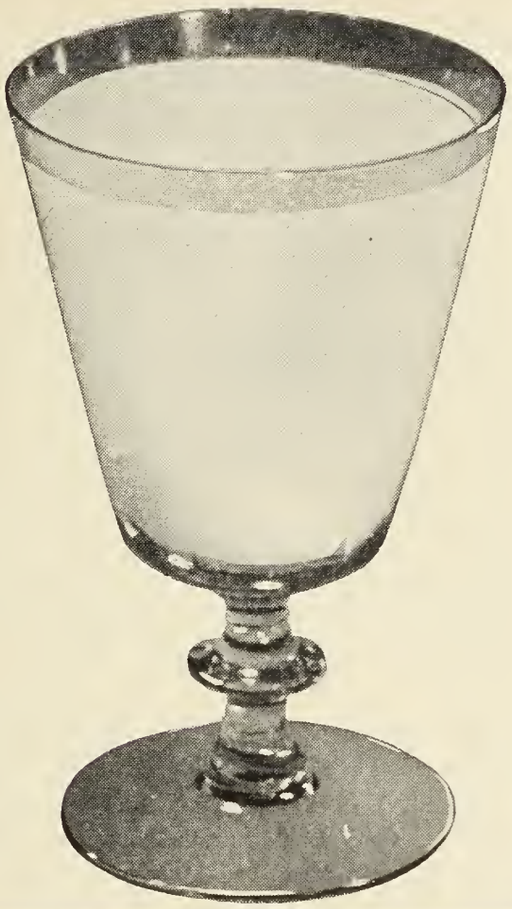
The U. S. House of Representatives Appropriations sub-committee, headed by Representative Frank B. Keefe of Wisconsin, liberally appropriated—for continuation of federal obligations under the Hill-Burton Hospital Construction Act—$60 million plus an additional $75 million authorized for contractual obligation.

* * *

Isador Falk admitted to a Congressional committee that hospital construction legislation is part of the scheme for national compulsion, in the following words: "The construction of hospitals is an essential and integral part of any program for compulsory health insurance for any considerable number of people, in that it is an element in the program to provide the facilities necessary for a health program."

(Continued on Page 558)





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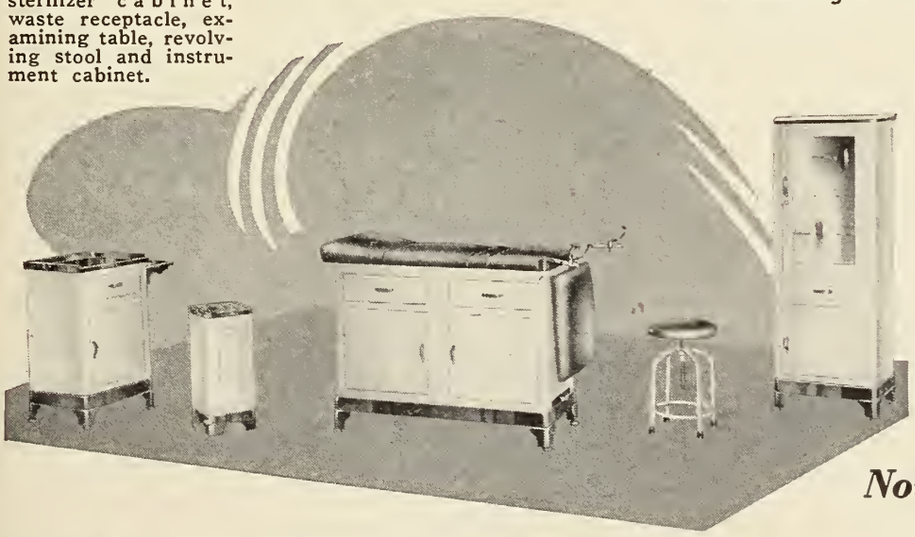
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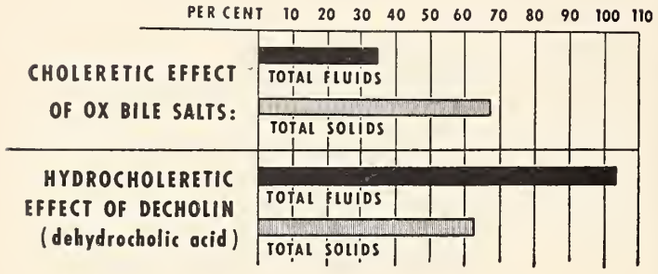
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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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(Continued from Page 556)

The American Congress of Physical Medicine will hold its 26th Annual Scientific and Clinical Session December 7-11, 1948, at Hotel Statler, Washington, D. C. For program, write the Secretary, 30 N. Michigan Ave., Chicago 2, Illinois.

* * *

The American College of Anesthesiologists announces that its April and October 1948 written examinations will be the last prior to raising requirements for Fellowship. Further information may be obtained by writing Donald L. Burdick, M.D., 745 Fifth Ave., New York 22, N. Y.

* * *

Daniel Blain, M.D., formerly Chief of Neuropsychiatric Service for the Veterans Administration, has accepted the newly established position of Medical Director of the American Psychiatric Association, with temporary headquarters at Suite 924, 9 Rockefeller Plaza, New York 20, N. Y.

* * *

The International Congress on Obstetrics and Gynecology will be held at the Hotel Pennsylvania on May 14-19, 1950, according to an announcement from the Board of Directors of the American Committee on Maternal Welfare of which Fred L. Adair, M.D., Chicago, is general chairman.

* * *

The American Physicians Art Association invites M.D. artists to exhibit at the Chicago AMA exhibition, June 21-25. Entry blanks, which must be returned before June 12, are available by writing the Association Secretary, Francis H. Redewill, M.D., Flood Bldg., San Francisco, California.

* * *

E. C. Texter, M.D., Detroit, vice president of the American Academy of General Practice, was guest speaker at the 11th Annual Clinic Day of the Alumni Association, University of Buffalo, in Buffalo, New York, on April 17. His subject was "The General Practitioner and the American Academy of General Practice."

* * *

D. B. Wiley, M.D., of Utica, Michigan, is on the program of the 1948 National Conference of County Medical Society Officers, to be held at the Palmer House, Sunday, June 20. Dr. Wiley will participate in a panel discussion on "The County Medical Society—Its Responsibility to the Public."

* * *

Michigan State Board Examinations.—The Michigan State Board of Registration in Medicine will conduct examinations on Wednesday, Thursday and Friday, June 9, 10 and 11, 1948, concurrently in Waterman Gymnasium, Ann Arbor, Michigan, and the Auditorium of the College of Medicine, Wayne University, Detroit, Michigan.

E. F. Sladek, M.D., Traverse City, MSMS president-elect, was a member of the panel discussion on "Toward Better Nursing Care," arranged by the Michigan Nursing Center Association on the occasion of its annual meeting in Grand Rapids, May 13-14-15. The discussants represented medical, hospital, nursing and consumer groups.

* * *

Letter from Oscar Speaker.—"It will probably interest you to know that in a recent contest sponsored by Speaker's in which listeners were invited to give opinions of 'Tell Me, Doctor,' there was much praise for the educational value to the average audience, and for the counsel relative to co-operation with the doctor on the part of the patient."

* * *

L. H. Newburgh, M.D., Professor of Clinical Investigation, The Medical School, University of Michigan, Ann Arbor, Michigan, read a paper before the centennial meeting, Section of Medicine, The New York Academy of Medicine, which was published in their *Journal,* March 1948. The paper was entitled, "Renal Tubule Work: Its Significance for the Clinician."

* * *

Orchids to JMSMS.—"I would like to say again that the recognition given our Michigan Society for Crippled and Disabled Adults, Inc., by your Michigan State Medical Society is the finest ever accorded us by any professional group. I was tremendously gratified by it. I hope that we can soon merit such recognition from other state medical groups."—Lawrence J. Linck, executive director, National Society for Crippled Children and Adults, Inc., March 26, 1948.

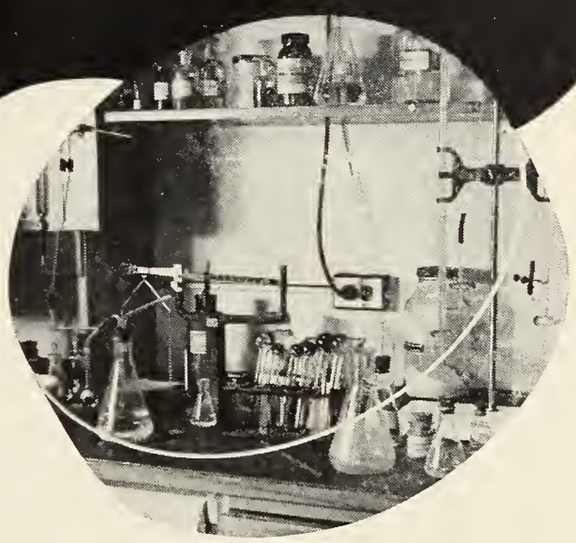
* * *

The Ingham County Medical Assistants Society was formed December 2, 1947, the original group consisting of thirty-five doctors' and hospital assistants. Mrs. Wm. R. Nelson was elected president; Miss Margaret Myers, vice president; Mrs. Clella Penner, recording secretary; Miss Mildred Deacon, corresponding secretary; and Miss Mary Rita Patterson, treasurer. Meetings are being held on the fourth Tuesday of every month in the Auditorium of the St. Lawrence Hospital Nurses Home.

* * *

U. S. Federal Security Agency has granted the University of Michigan $6,862 for the co-ordinated teaching of undergraduate medical students in the field of cancer. An additional $9,200 was given the U. of M. Medical School to study (a) the effect of carcinogenic agents on artificially produced gastric ulcers in animals; (b) an evaluation of the aspiration technique (Papanicalaou) in detecting carcinoma cell from gastric washings in humans. FSA also granted the Michigan Department of Health $25,160 for method of cancer morbidity reporting.

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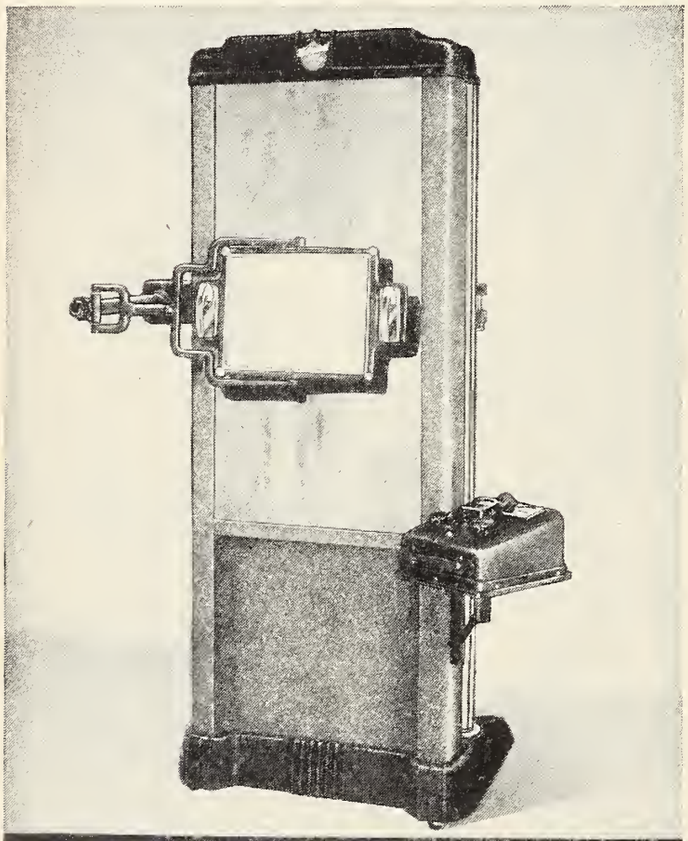
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Richard P. Strong Medal.—The American Foundation for Tropical Medicine has made its annual presentation of the Richard P. Strong Medal for distinguished service in the field of tropical medicine to Dr. Neil P. Macphail, Medical Superintendent, East Coast Division, United Fruit Company, Quirigua, Guatemala. Dr. Macphail has spent forty years caring for untold thousands of natives. He was a pioneer in the eradication of plague, yellow fever, and smallpox in that area.

* * *

The Naval Air Reserve Training Command, with headquarters at Naval Air Station, Glenview, Illinois, has eighteen nationally located Naval Air Stations and four Naval Air Reserve Training Units, at which Naval Reserve Medical Officers may serve on active duty with full pay and allowances and with the privilege of returning to civilian life at any time upon request. Additional details may be obtained from Chief of Naval Air Reserve Training, Naval Air Station, Glenview, Illinois.

* * *

The American College of Surgeons Board of Regents, on February 22, adopted a resolution commending the services of nurses who have had special training in the administration of anesthesia. Part of the resolution read: "The ACS is of the opinion that, in view of the inadequacy in number of the physician anestheologists and in view of the splendid record of achievement of the nurse anesthetists, institutions engaged in the training of nurses for this purpose should be encouraged to continue their program."

* * *

The American College of Chest Physicians announces that the next oral and written examination for Fellowship will be held in Chicago, June 17, 1948. Candidates should contact the Executive Secretary, 500 N. Dearborn Street, Chicago 10, Illinois.

The fourteenth annual meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, on June 17-20, 1948, immediately preceding the American Medical Association Annual Session.

* * *

Two Blue Shield Plans Pass 700,000 Members.—With the release of 1947 enrollment reports, AMCP announced that two Blue Shield plans had passed the 700,000 mark in enrollment. United Medical Service in New York City reported a total enrollment on December 31, 1947, of 729,794 persons, while Massachusetts Medical Service reported, as of the same date, an enrollment of 725,519.

Michigan Medical Service still tops the list with 1,030,000 persons enrolled.

* * *

H.R. 4978 in the U. S. House of Representatives proposes to remunerate Reserve Flight Surgeons on the same basis as Reserve Air Corps personnel. This is a Michigan sponsored bill, introduced by Congressman Fred L. Crawford. H.R. 4978 is also sponsored by the Association of Military Surgeons.

Doctors of Medicine who were Flight Surgeons are re-

(Continued on Page 562)



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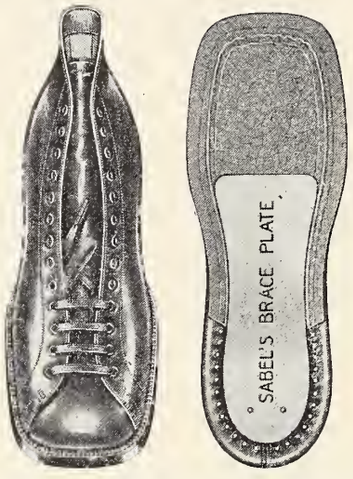
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(Continued from Page 560)

quested by R. D. Mudd, M.D., 1001 Hoyt St., Saginaw, surgeon, Michigan Department, Reserve Officers Association, to contact their U. S. Senators and Congressmen regarding the need for H.R. 4978. Physicians who were Flight Surgeons prior to July 1, 1942, are requested to write Dr. Mudd.

* * *

L. Fernald Foster, M.D., Bay City, MSMS secretary, will address the Upper Peninsula Medical Society at its meeting of June 25-26 at the "Five-Hundred Bushel Club," near Ironwood. His subject will be "Making More Friends for Medicine."

Dr. Foster addressed the Rotary Club of Adrian on May 13. His subject was "Political Medicine."

On June 2 Dr. Foster speaks to the South Dakota State Medical Association in annual convention at Sioux Falls, on the subject "Medicine's Future is the Responsibility of Every Individual Practitioner—Today."

* * *

Dr. Robert Gesell, Professor of Physiology and Chairman of the Department of Physiology of the University of Michigan Medical School, spoke on "New Concepts of Physiology of the Central Nervous System" at a seminar of the Research Division of Smith, Kline & French Laboratories held on March 12. His speech covered the physiology of the individual neuron; the manner in which simple groups of nerve centers function; interpretation of the action of drugs on nerve centers; and analogies between the functions of the respiratory center and the functions of the higher nervous centers. Dr. Gesell, one of the country's outstanding physiologists, has had an SKF grant since 1946, and has been carrying on extensive research work in cholingeric physiology.

* * *

Chicago Blue Shield.—With a front page story in the Chicago *Tribune* on February 9, announcement was made of the establishment of a new Blue Shield plan in Chicago.

Chicago Medical Service (Blue Shield Plan) is sponsored by the Chicago Medical Society, and will be administered by the Blue Cross organization, of which Edson P. Lichty is the executive director.

Inquiries received during the day on which the story appeared reached a staggering total of 1,200 Blue Cross groups, all of whom wanted to know when their members could enroll in Blue Shield. The aggregate number of people involved during the first day's inquiries totalled more than 100,000 persons.

* * *

Income Tax Evasion.—The income tax returns of physicians have been minutely examined for evasions by a special income tax detail in the Chicago area. Of the first five doctors chosen at random, all were found guilty of withholding income from their returns. The result of this finding will be that if the Bureau of Internal Revenue can obtain the necessary appropriations from Congress, it will conduct a systematic investigation of physicians in all sections of the country. This is part of a general drive by the Treasury Department to col-

(Continued on Page 564)

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(Continued from Page 562)

lect an estimated 400 million dollars lost annually in evaded income taxes.—American College of Radiology *News Letter,* February, 1948.

(The Editor has been told that the Internal Revenue officers visited some hospitals in Detroit and asked for lists of patients that doctors had cared for in the hospital during the year.)

* * *

Hospital Rates Increase.—The City of Detroit has increased the hospital rates, effective April 1, 1948. At Redford Receiving the rates are raised from $13.00 per day to $23.00. The Welfare Commission has recommended to the Common Council that the Redford Receiving Branch be closed during the coming fiscal year beginning July 1, 1948, as an economy measure, and that by special arrangement the private hospitals in the area accept City emergency cases.

Downtown Receiving Hospital will raise rates from $13.00 to $13.75 per day for medical and surgical ward patients. The psychopathic ward rates will increase from $7.55 to $10.00. Herman Kiefer rates will go from $8.75 to $9.25 per day.

* * *

Wm. J. Burns, Lansing, MSMS executive secretary, will act as moderator for a round table discussion on "Convention Management" a feature on the program of the Medical Society Executives Conference in Chicago on June 23. Other members of the round table discussion are C. P. Loranz of the Southern Medical Association, M. C. Smith, Nebraska State Medical Society, T. E. Hull, Director of Scientific Exhibits at the American Medical Association, and C. S. Nelson of the Ohio State Medical Society.

Mr. Burns addressed the South Dakota State Medical Association in Sioux Falls on May 29. His address at the dinner for association officers and the exhibitors was entitled "Taking the X out of Exhibits."

* * *

The Michigan State Pharmaceutical Association, agent in Michigan for the Veterans Administration "hometown pharmaceutical care program of veterans," announces the availability of the following USP and NF products "in an effort to establish prescribing practice which will permit the dispensing of the highest quality drugs for veterans at the lowest possible cost to the Veterans Administration":

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5. Mild mercurous chloride ointment (Unguentum hydrargyri chloridimitis).
6. Compound tar ointment (Unguentum picis composition).

* * *

Leonard A. Scheele, M.D., became Surgeon General of the United States Public Health Service on April 6, upon expiration of the term of Thomas Parran, M.D.

Forty years old, Dr. Scheele becomes the youngest Sur-

(Continued on Page 566)



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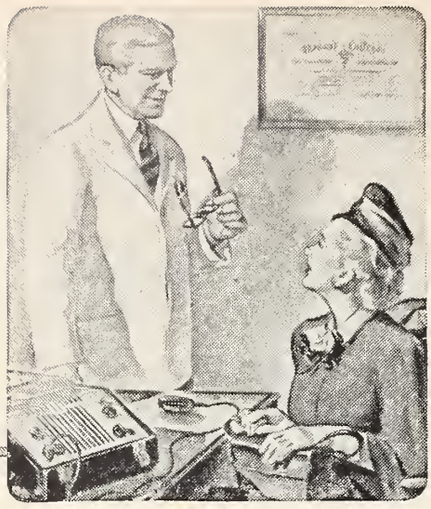
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Surgical Technique, Surgical Anatomy & Clinical Surgery, four weeks, starting May 24, June 21, August 2.
Surgical Anatomy & Clinical Surgery, two weeks, starting May 10, June 7, July 6.
Surgery of Colon & Rectum, one week, starting May 24, June 14.
Surgical Pathology every two weeks.
UROLOGY—Intensive course, two weeks, starting September 27.
FRACTURES & TRAUMATIC SURGERY—Intensive course, two weeks, starting June 7.
OPHTHALMOLOGY—Intensive course, two weeks, starting May 10.
Ocular fundus diseases, one week, starting June 7.
GYNECOLOGY—Intensive course, two weeks, starting June 7, September 13.
Vaginal approach to pelvic surgery, one week, starting June 21.
OBSTETRICS—Intensive course, two weeks, starting June 21, September 27.
MEDICINE—Intensive course, two weeks, starting June 7.
Personal course in Gastroscopy, two weeks, starting June 28, July 12.
Electrocardiography and Heart Disease, two weeks, starting August 2.
Hematology, one week, starting May 10.
Gastroenterology, two weeks, starting May 24.
DERMATOLOGY—Formal course, two weeks, starting June 7.
Clinical course every two weeks.
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(Continued from Page 564)

geon General in the country's history. He is a native of Fort Wayne, Indiana, where he was born July 25, 1907. He received his A.B. from the University of Michigan in 1931; his B.S. in medicine in 1933 and his M.D. in 1934, both from Wayne University College of Medicine, Detroit.

Dr. Scheele was commissioned in the USPHS in 1934. Dr. Scheele is married and the father of three children. He achieved a splendid record in Italy and later with SHEAF. It is said that his disarming candor and refreshing informality add to his effectiveness in getting things done. His work with the National Cancer Institute, combining relations with the American Cancer Society, greatly improved the internal reorganization of the Institute.

* * *

Michigan Medical Service.—Will Blue Cross pay the doctor for my operation? How can I get Blue Cross protection for myself and my family? How does the hometown care for veterans work?

These are some of the many questions about Michigan Medical Service and Michigan Hospital Service, the Blue Cross Plans, that patients ask doctors' assistants and secretaries in the course of an average day.

Recognizing, consequently, that the doctor's assistant and secretary are important sources of information regarding Michigan Medical Service, Blue Cross has initiated a series of luncheon and dinner meetings in cities throughout the state to discuss its program of prepayment hospital-surgical-medical care.

MMS field representatives arrange these educational meetings in co-operation with the doctors of the local county. The first of the luncheons was held last fall in Grand Rapids when 125 members of the Grand Rapids Medical Assistants Association attended as guests of Blue Cross. On February 16, members of the newly organized Medical Assistants Association of Holland were invited to a similar dinner meeting. The doctors' assistants and secretaries in Muskegon attended a luncheon on February 17, and on February 19 the doctors' assistants and secretaries of South Haven and Bangor were guests of Blue Cross at a dinner in South Haven. Other meetings are planned for Saginaw, Bay City and other areas.

* * *

Dr. Russell L. Mustard flew to Japan in April to serve about five weeks as a civilian consultant for the army's surgeon general in the Far East theater.

Dr. Mustard is one of two surgeons selected by Maj. Gen. R. W. Bliss, army surgeon general, to serve as civilian consultants to medical officers now stationed in Japan and Korea.

The other consultant is Dr. Paul C. Colonna of Philadelphia, professor of orthopedic surgery at the University of Pennsylvania, who joined Dr. Mustard in Washington, D. C. They left Washington by air Tuesday morning, April 20, and arrived April 23 in Tokyo early Friday morning, where they reported to General MacArthur.

Dr. Mustard and Dr. Colonna are the first civilian phy-

(Continued on Page 568)

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(Continued from Page 566)

sicians to be selected by General Bliss to go to Japan and Korea to improve further the quality of medical care and instruction in army medical installations in the Far East.

Dr. Mustard visited fourteen army hospitals in the three main Japanese islands and Korea, conducting clinics, making ward rounds, lecturing to army doctors, and conducting such other teaching functions as may be required at each of the hospitals. His visit to the army hospitals is in line with a recently established army policy of training army doctors for various medical board specialties, which normally require five or six years' hospital training to meet board membership requirements.

Dr. Mustard expects to return to his civilian practice in Battle Creek about the first week in June. He has been serving as a civilian consultant to Percy Jones General hospital and Fort Custer Veterans Administration Hospital.

* * *

The Oklahoma State Medical Association is sponsoring a post-AMA-Convention tour through the Canadian Rockies, and invites all MSMS members to join in this thirteen-day all-expense rail journey. Beginning Friday, June 25, the special train will visit Lake Louise, Banff, Jasper Park, Columbia Icefield, Emerald Lake, Yoho Valley, and the Calgary Stampede. For information, write Dick Graham, Oklahoma State Medical Association, 210 Plaza Court, Oklahoma City 3.



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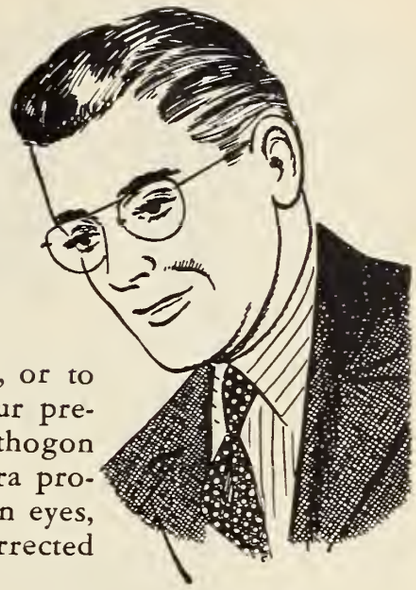
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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

TREATMENT BY DIET. By Clifford J. Barborka, B.S., M.S., M.D., D.Sc., F.A.C.P., Assistant Professor of Medicine, Northwestern University Medical School; Attending Physician, Passavant Memorial Hospital; Consultant in Gastro-enterology and Gastropy, Diagnostic Center, Hines Veterans Hospital; Formerly Consulting Physician, The Mayo Clinic. Fifth Edition. 14 Plates, including 13 in color. Philadelphia: J. B. Lippincott Company, 1948. Price $10.00.

It is nine years since the fourth edition of this book, and the tremendous advances in the field of nutrition have called for the rewriting and expansion of approximately half of the material. New knowledge in protein and amino acids, new discoveries in the synthesis of vitamins have added to the work. Diets are given for every form of treatment needed; also for weight reducing. A chapter is devoted to deficiency states. Underweight and emaciation are discussed with suggested diets of 2,600, 3,000, and 3,600 calories. Addison's disease, hyperinsulinism, ketogenic diets—all receive full attention. This is one of the most readable and useful books we have seen. It would be indispensable for hospitals and homes for convalescents, as well as any place where well-regulated diets are required.

OCCUPATIONAL MEDICINE AND CLINICAL HYGIENE. By Rutherford T. Johnstone, A.B., M.D., Consultant in Industrial Health; Lecturer at the University of California, Los Angeles; Formerly Assistant Professor of Medicine, University of Pittsburgh School of Medicine; Formerly Director of Department of Occupational Diseases, Golden State Hospital. With One Hundred Seventeen Illustrations. Seven in color. St. Louis: The C. V. Mosby Company, 1948. Price $10.00.

This is a new book covering a comparatively new field of medicine. Industrial hygiene is just beginning to be understood for its great value, and the field of occupational medicine needs new advocates. This book is designed to fill this need. Every effort is made to complete the picture of the growing specialty. One must have this information to work extensively or efficiently in this branch of medicine. This work is not confined to specialists, which all the more points to this book for the practitioner who must take these responsibilities. The occupational conditions suffered by workers call for skillful and well-advised attention. This book carries the guidance.

A MANUAL OF PHARMACOLOGY AND ITS APPLICATIONS TO THERAPEUTICS AND TOXICOLOGY. By Torald Sollmann, M.D., Professor Emeritus of Pharmacology and Materia Medica, School of Medicine, Western Reserve University, Cleveland. Seventh Edition. Philadelphia and London: W. B. Saunders Company, 1948. Price $11.00.

A rather comprehensive advance in drug therapy due to the antibiotics and chemotherapy has called for much detailed consideration. This book is a very complete compendium of the study of drugs and their actions with especial reference to treatment of disease, and in toxicology. Most of the book is printed in two columns and contains the expected studies of the various drugs and chemicals. The atomic formulas are given in many

(Continued on Page 472)



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(Continued from Page 570)

cases. Drugs are grouped as to action and use, and are studied as to their inter-relations, and simularities. This book is a complete pharmacology, and offers a most accessible form of reference. Long a standard work, this edition is no exception.

SYMPOSIUM ON MEDICOLEGAL PROBLEMS. Under the co-sponsorship of the Institute of Medicine of Chicago and the Chicago Bar Association. Edited by Samuel A. Levison, M.D., Ph.D., University of Illinois College of Medicine for The Committee of the Institute of Medicine and the Chicago Bar Association. Philadelphia: J. B. Lippincott Company, 1948. Price $5.00.

This book is a collection of very able essays on many subjects, such as: The Medical Witness, Expert Testimony, Artificial Insemination — Medical Aspects and Legal Aspects, The Practice of Pathology and its Medico-Legal Problems, Operations to Produce Sterility—Medicolegal Implications, Trauma and Tumors in Industrial Medicine, Scientific Tests in Evidence. Each of these subjects is given from the medical and the legal aspect, and each has a discussion and question period. This is a valuable book for anyone interested in the medicolegal applications of medicine and medical problems.

ADVANCES IN MILITARY MEDICAL SCIENCE IN WORLD WAR II. Office of Scientific Research and Development. Made by American investigators working under the sponsorship of The Committee on Medical Research. Edited by E. C. Andrus, D. W. Bronk, G. A. Carden, Jr., C. S. Keefer, J. S. Lockwood, J. T. Wearn and M. C. Winternitz; Associate Editor, Tuckerman Day. Foreword by Alfred N. Richards. Two volumes with illustrations. An Atlantic Monthly Press Book. Boston: Little, Brown and Co., 1948. Price $12.50.

This set of books is part of the official record of medical advance during World War II. Medical men and their associates made great advances in science, in research, and in treatment of many forms of disease. These are all recorded. War has always meant advance in the scope of medical and surgical opportunities and achievements, and this war emphasized that feature far more than any other. It is impossible even to suggest the mass of research and the extensive fields of study. They included venereal diseases and their control, tropical diseases, prevention of wound infection, experimental wound healing, application of penicillin to surgical problems, gas gangrene, repair of peripheral nerve lesions, anoxia and oxygen equipment, history of plasma fractionation, acclimatization to heat and cold, new insecticides, chemical warfare, anti-pest agents. And that

is nowhere near half of the titles. This set of books is the fourth in the series on the history of the Office of Scientific Research and Development and describes only one division of endeavor. It is complete in itself, and contains a world of facts and usable data.

BRIEF PSYCHOTHERAPY. By Betrand S. Frohman, M.D., with foreword by Walter C. Alvarez, M.D. Philadelphia: Lea & Febiger, 1948. $4.00.

This is a handbook for physicians on the clinical aspects of neuroses. Practitioners, especially general practitioners, will find it full of helpful information and thought-producing case histories, with the most complex phases of psychotherapy presented and explained in brief, understandable, concise language. The text is easy to read and understand. "Brief Psychotherapy" was written by a man who for years was in general practice and who maintained his interest in patients, not in cases. The book contains practical advice as to treatment.

PENNSYLVANIA ALUMNI DINNER

University of Pennsylvania Medical Alumni will hold a dinner at the convention of the American Medical Association in Chicago, Wednesday, June 23, 1948, at the Lake Shore Club, 850 Lake Shore Drive. On arrival in Chicago, alumni should contact Miss Frances R. Houston, Executive Secretary of the Medical Alumni Society, at the University of Pennsylvania registration booth.

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"Twenty-four hours after Dr. Magnussen said that 6,000 beds in VA hospitals are closed for lack of medical personnel, Army Engineer Corps announced proudly that construction progress has doubled that of last year. During the first three months of 1948, $88,674,631 in contracts for twelve new VA hospitals were awarded, bringing to twenty-three the total of institutions under contract for construction (total cost $194,253,000). Seven more have been or soon will be advertised for bids."—Washington Report on the Medical Sciences, April 5, 1948.

* * *

"I am absolutely against any kind of socialized medicine or compulsory government sickness insurance," stated New York's Governor Thomas E. Dewey, several days ago, according to the AMA Secretary's Letter of April 12, 1948. Governor Dewey believes that any compulsory national sickness insurance would reduce the medical profession to a level of "government mediocrity."

* * *

More than 109,000 patients were hospitalized by the Veterans Administration on March 1.

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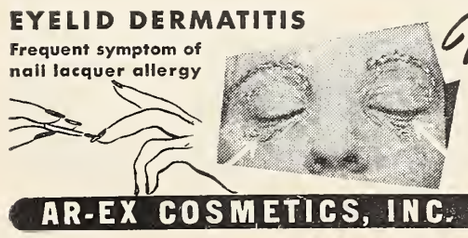
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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of May 19, 1948

• Monthly financial reports and bills payable were presented, studied and approved.

• Public Relations Committee Chairman L. W. Hull, M.D., Detroit, reported on conference in Washington, D. C., between an MSMS Committee and the Medical Director of the United Mine Workers on union's so-called health and welfare fund.

• Report on Basic Science Law administration and the B.S. Board's recent establishment of reciprocity with Iowa, was presented by President P. L. Ledwidge, M.D. Basic Science and graduate training in hospitals was discussed.

• Reports accepted from the Legislative Committee concerning the Special Session of 1948, from the Mental Hygiene Committee (two meetings), Committee on MSMS Dues Structure, Postgraduate Medical Education Committee, Public Relations Committee, Committee on Emergency Medical Service, Cancer Control Committee, Committee on Rheumatic Fever Control, Committee on Standards for Medical Office Assistants of the Department of Public Instruction, and also on the Michigan Congressional Dinner held in Washington, D. C., in April.

• Report on nation-wide USPHS-sponsored meetings with hospital administrators re Federal Hospital Survey and Construction Act was presented. Commendation was given MSMS Liaison Committee with Michigan Hospital Association on its effective work of co-operation.

• Joint meeting with Michigan's eight Delegates to AMA was held and six matters for reference to AMA House of Delegates were discussed and agreed upon—including resolution re Blue Cross and AMA employes' coverage.

• R. L. Novy, M.D., Detroit, Wilfrid Haughey, M.D., Battle Creek, and E. F. Sladek, M.D., Traverse City, appointed a Committee to attend Chicago meeting called to consider the merging of Blue Cross and Blue Shield.

• President Ledwidge reported 262 new members had been certified to AMA as the result of the MSMS Membership Month campaign held in April, 1948.

• Secretary instructed to congratulate Congressman Harness on his fearless exposé of misuse of Federal funds to encourage socialization.

• Appropriate action on California Medical Association telegram, advising of Governor Earl Warren's plan for compulsory health insurance, was taken.

• Monthly reports of President P. L. Ledwidge, M.D., President-Elect E. F. Sladek, M.D., Secretary L. Fernald Foster, M.D., General Counsel J. Joseph Herbert, and Public Relations Counsel H. W. Brenneman accepted.

• The Chair expressed thanks to the members of the Executive Committee for their good advice and understanding patience during this ten-hour session of the Executive Committee.

OVER A MILLION COVERED BY MMS

Enrollment in Michigan Medical Service, the Blue Cross Plan for prepaid medical-surgical care, went over the million mark on May 1. Figures as of May 1 bring the number of subscribers to 1,100,000, an increase of approximately 250,000 persons over the number enrolled in 1946.

Among the factors to which Blue Cross enrollment officials attribute the increase is the 1947 liberalization of the Blue Cross medical-surgical certificate, which provides for care in the doctor's office and out-patient department of a hospital where the fee, in accordance with the MMS Schedule of Benefits, is $20 or more.

Another factor of significance given for the increase is an expanding acceptance of the Blue Cross program. The subscriber must be a member of Michigan Hospital Service, companion organization to Michigan Medical Service, in order to be eligible for the medical-surgical plan, as both organizations, with certain exceptions, provide benefits only to the subscriber who is a bed-patient in the hospital. Companies which have been enrolled in Michigan Hospital Service are gradually passing from the "experimental period" of the enrollment, have found Blue Cross satisfactory, and are interested in providing the broader benefits of medical and surgical protection for their employes.

Co-operation of members of the Michigan State Medical Society with Blue Cross on community enrollments has its public education aspects. Initial purpose of the community enrollments is to make Blue Cross protection available to those persons ordinarily not eligible for Blue Cross membership, as Blue Cross is usually available only to established groups of five or more employes.

Co-operating in a county-wide Blue Cross enrollment in Clinton County in December were W. B. McWilliams, M.D., chief of staff of Clinton Memorial Hospital, and S. R. Russell, M.D.,

(Continued on Page 700)



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William Withey Gull

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SIR William Gull is medically recognized for his many original observations which led to his classic description of myxedema and a greater understanding of nephritis. He also added much to the fundamental knowledge of neuropathology—such as his observations that locomotor ataxia was a disease of the posterior columns of the spinal cord. Medical knowledge was greatly enriched by Gull's experiences.

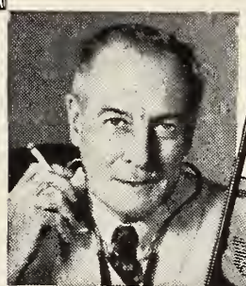
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OVER A MILLION COVERED BY MMS

(Continued from Page 698)

president of the Clinton County Medical Society.

On the Blue Cross committee for a community enrollment held in South Haven and Bangor in February were E. H. Terwilliger, M.D., chief of staff of South Haven Hospital, M. W. Buckborough, M.D., and Avison Gano, M.D.

The Upper Peninsula will have an opportunity for a Blue Cross community enrollment within the next few weeks. All such enrollments, it is emphasized by Blue Cross officials, are being undertaken only where there is a request from the local hospital and doctors.

AMA COMMITTEE'S REPORT ON HOSPITAL PRACTICE OF MEDICINE

"The practice of medicine by hospitals has been a moot subject for many years. . . . This has applied particularly to the four specialties of anesthesiology, pathology, radiology and physical therapy. . . . It would appear that at least we should insist upon the following: (1) recognition that the specialties of pathology, radiology, anesthesiology and physical therapy are the practice of medicine; (2) all specialists in a hospital should be under the jurisdiction of the medical board; (3) all specialists should be on the staff of the hospital and be represented on the medical board; (4) conditions of employment will vary locally and they must have the approval of the medical board of the hospital, whose responsibility it should be to see that these provisions are carried out; (5) the interests of the general public should be paramount and local conditions must be taken into consideration; (6) there must be co-operative understandings with the hospitals and specialists groups, and (7) it is recommended that the AMA House of Delegates request the Board of Trustees to appoint a committee to study the various resolutions passed previously by the House and that this committee be directed to arrange conferences with the hospital associations and the various specialist societies, in order that a solution may be worked out which will be fair to all parties and redound to the benefit of the public."

MICHIGAN'S SUCCESSFUL IMMUNIZATION CAMPAIGN

The State-wide immunization campaign against small pox, diphtheria, whooping cough and tetanus was inaugurated February 15 and ran for a period of forty-five days.

The comments of the Michigan Department of Health on this successful campaign, inaugurated by the Michigan State Medical Society, follow:

"Michigan's immunization campaign which got under way during February, 1948, has met and is still meeting with encouraging success. Although no figures are available at this time on the exact number of children immunized, the State Health Department records show that enough biologic products were distributed by that agency during February to protect approximately 100,000 children. This does not take into account the quantities of commercial products used during the period. It is estimated that there are 600,000 preschool children in the state.

"There is no over-all pattern for the administration of the program. Details have been worked out on individual city, county or district bases between the health department directors and the physicians in those areas. In most places the work is done co-operatively—some parents take their youngsters to the offices of their health department; others go to their physicians' offices. In a few areas, the immunizations are done in the schools by the private physicians or the health officers.

"The Michigan Department of Health has received a number of reports on the program from health officers in many areas of the state indicating that the campaign has been statewide in its scope. All of these reports implied close co-operation between local health departments and local medical societies.

"Newspapers, both weekly and daily, have taken a very active part in the promotion of the campaign. Editorial comment of these papers has done much to add to the success of the program."

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The following model sickness claim blank, developed by the American Medical Association Council on Medical Service, has been drafted to the end that all necessary information is provided the insurance company but that unnecessary data and red tape are eliminated:

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   Was patient confined to a hospital?
   Name of hospital?
6. Dates of treatments? Office
7. When was, or will patient be, able to resume any part of his work? Home:
   Date 19

If you wish to amplify, please use this space.

Date.....19.....

Signed .....

Attending Physician

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Street and Number Town State

(Continued on Page 702)



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SCHERING

(Continued from Page 700)

RESOLUTION ON NONPROFIT PREPAYMENT MEDICAL CARE PLANS

WHEREAS, the American Medical Association on many occasions has encouraged the formation of nonprofit voluntary prepayment hospitalization and medical service plans by its constituent state and county societies; and

WHEREAS, these constituent state and county societies have participated in the formation and development of nonprofit voluntary hospitalization programs (nationally known as Blue Cross hospitalization plans) and nonprofit medical surgical service programs (nationally known as Blue Shield plans); and

WHEREAS, the action of the American Medical Association in canceling its contract with the Chicago Blue Cross and Blue Shield plans which provided hospitalization and medical surgical coverage for the employes of the American Medical Association and in contracting with a commercial insurance company for the same coverage was not in the best interest of the medical profession as a whole or the voluntary Blue Cross and Blue Shield plans; and

WHEREAS, this action of the American Medical Association has already by adverse publicity caused serious embarrassment to the Blue Cross and Blue Shield plans; therefore be it

RESOLVED, That the House of Delegates of the American Medical Association instruct its Board of Trustees to immediately cancel the contract with the commercial insurance company and reinstate the contract with the Blue Cross and Blue Shield plans.—*Resolution, Missouri State Medical Association, J.A.M.A., May 8, 1948.*

CHICAGO MEDICAL SOCIETY OFFERS POSTGRADUATE COURSES

The Chicago Medical Society is sponsoring two postgraduate courses in September to be given in Thorne Hall on the campus of Northwestern University Medical School, Lake Shore Drive and Superior Street, Chicago.

The first course in "Hematology and Neurology" will be given the week of September 13-18, 1948. The second course in "Cardiovascular and Respiratory Diseases" will be offered the week of September 20-25.

Distinguished faculties of fifty-eight members from all over the United States will give the courses. There will be lectures, round tables, and intermissions which will give those taking the courses opportunity to meet and talk with the faculty.

Both courses are limited to 100 and are open to physicians in good standing in their local medical societies. For copy of program and application write Dr. Willard O. Thompson, Chairman, Committee on Postgraduate Medical Education, Chicago Medical Society, 30 North Michigan Avenue, Chicago 2.

Political Medicine

S. RES. 249 MARKS THE END OF THE W-M-D ERA OF NATIONAL HEALTH LEGISLATIVE PROPOSALS

The complete text of S. Res. 249 is given below. It brings to a conclusion some 60-odd public hearings on compulsory sickness insurance, extending over three years and covering S. 1606 of the 79th Congress and S. 1320 of the 80th Congress.

"*Resolved,* That the Senate Committee on Labor and Public Welfare is hereby authorized and directed through the Subcommittee on Health of the said committee to—

"(a) continue its study of the health problems of the Nation and of legislative proposals relating thereto which have been referred to the said subcommittee, which study shall be primarily concerned with ascertaining the full extent and nature of existing national health problems and the action, if any, which the Federal Government should take in relation to said problems;

"(b) consult, in the course of such study, with Federal agencies administering health and related programs, with such other legislative committees of the Senate as are concerned with related matters, and with such other agencies, organizations, or persons as the subcommittee may desire to consult;

"(c) report to the Senate not later than March 15, 1949, the results of the study, together with such proposed legislation, if any, and such other recommendations as the subcommittee may deem desirable.

"Sec. 2 (a) The Senate Committee on Labor and Public Welfare, through the said Subcommittee on Health, is authorized to sit and act at such times and in such places during the sessions, recesses, and adjourned periods of the Eightieth Congress, to employ such consultants, clerical, and other assistance, to procure such printing and binding, to require by subpoena or otherwise the attendance of such witnesses and the production of such books, papers, and documents, to administer such oaths, to take such testimony, and to make such expenditures, within the limits below set forth, as it deems advisable. The cost of stenographic services to report such hearings shall not be in excess of 25 cents per hundred words.

"(b) The expenses incurred under this resolution, which shall not exceed $10,000, shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee."

FULL-SALARIED SERVICE

The B.M.A. is not able legally to act as a trade union, and in a nationalized service the need for such a protective body is glaringly necessary, and the sooner the better.—*Editorial, British Medical Journal, May 22, 1948.*

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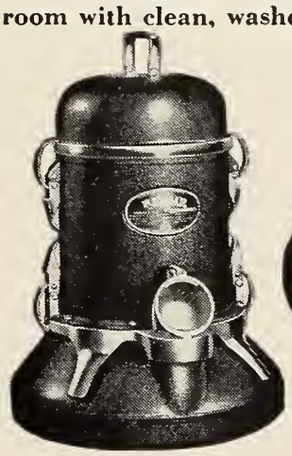
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PR in Practice

Second Rural Health Conference

The Second Annual Rural Health Conference is planned for September 16 and 17 on the campus of Michigan State College, H. B. Zemmer, M.D., Lapeer, announced following a meeting of the Committee on Arrangements in Lansing on May 27.

Last year's conference, sponsored by the Michigan State Medical Society and co-sponsored by medical and lay groups interested in improving health services for rural residents, attracted widespread interest in Michigan, and has since set the pattern for similar action in other states.

Representatives of the sponsoring agencies will meet in July to plan the program for this year's conference. Suggested discussion topics include the federal aid program for hospital construction, the "Medical Associates" project, improving rural health through the schools, and health and hospital insurance.

First Rural Health Conference Brochures

The brochure of the first Michigan Rural Health Conference and a review of the progress of the activities called for by the resolutions of the 1947 Conference have been completed and are now being distributed. Copies may be obtained by writing Michigan Rural Health Conference, 2020 Olds Tower, Lansing 8, Michigan.

Cinema Progress Report

After a final check and double-check, the script for the motion picture prepared by Mr. Frank Goldman under the direction of the MSMS Committee on Cinema is ready for filming by the Jam Handy Corporation of Detroit. The completed picture will run ten minutes on the screen and is expected to be released before September.

It is anticipated that over a million persons will see the picture when it is distributed through the motion picture theaters of Michigan.

Arrangements have been made for the Metropolitan Life Insurance Company's moving picture "Be Your Age" to be shown in Michigan's theaters with a trailer outlining the MSMS Rheumatic Fever Control activities. The picture deals with the nature and characteristics of heart disease. The pamphlet "Your Child is Safer in Michigan" will be distributed in the theaters where the picture is shown through the co-operation of the Michigan Society for Crippled Children and Adults, Inc.

"Tell Me, Doctor"

The "Tell Me, Doctor" program is now being heard over twenty-two Michigan radio stations. The new additions are WJRP Ishpeming, WBCM Bay City, WTCM Traverse City, WDBC Escanaba, and WHRV Ann Arbor.

AMA Exhibit

The MSMS panel, which was a part of the "Rural Child Health" exhibit at the AMA convention in Chicago the week of June 21, shows by means of a photographic mural how the MSMS is co-operating with the health program of the Congress of Parents and Teachers by the establishment of Rheumatic Fever Control Centers, Sex Education Instruction programs, Immunization drives and training of Medical Associates.

Beaumont Memorial Shrine

A project to establish a Beaumont Memorial Shrine on Mackinac Island is being considered. Tentative plans are that the Early House will be rebuilt in its original form. Funds for the project will be obtained from voluntary sources.

The Council of the MSMS will consider the part the Society can play in this project at its meeting of July 22, 23, and 24.

It is felt by many that the restoration of this historical building will serve to acquaint thousands of people with the labors of individual M.D.s in aiding mankind to achieve a longer, fuller, and healthier life.

Woman's Auxiliary

The Woman's Auxiliary to the MSMS has completed a comprehensive public relations program for 1949. The plan sets forth the general over-all objectives of the Auxiliary, and suggests specific projects which may be undertaken by the various county auxiliaries.

Among these projects are plans for promoting the concept of Medical Associates among the young people of Michigan; assisting the Blue Cross-Blue Shield Plans in community enrollment drives; helping other health groups in their campaigns; and spurring the recruitment of nursing students.

P. R. Plan Receives "Legal" Recognition

Glenn R. Winters, Secretary of the American Judicature Society and editor of its Journal, addressed the Indiana State Bar Association on July 10, using the Michigan State Medical Society Public Relations program as an example of "what can be done." Mr. Winters termed the MSMS projects "extremely successful."

MEAT

And the Dietary of Pregnancy and Lactation

According to a study published in the recent past[1] it has been shown that nitrogen balance is suddenly reversed from positive to negative shortly before term. This negative balance is further intensified by substantial losses of nitrogen during parturition and the postpartum period. Lactation imposes still another burden on nitrogen metabolism.

This study again emphasizes the need for a diet rich in biologically complete protein during the latter half of pregnancy. In this manner, the physiologic loss of nitrogen at term can be compensated, avoiding negative nitrogen balance. A high protein diet has the further advantage of producing a more copious milk supply.

In another recent publication,[2] the prevention of the toxemias of pregnancy by dietary means was stressed. Foremost among the measures recommended was a diet rich in high quality protein to assure nitrogen balance.

Meat is an outstanding source of protein in the dietary of pregnancy and lactation for these four reasons: (1) It is notably rich in protein, from 17 to 20 per cent of its uncooked, and from 25 to 30 per cent of its cooked weight; (2) The protein of meat, regardless of cut or kind, is biologically complete; (3) The appetite appeal of meat is high, and (4) All meat is of excellent digestibility—from 96 to 98 per cent.

---

[1] Stuart, H.C.: Effects of Protein Deficiency on the Pregnant Woman and Fetus and on the Infant and Child, New England J. Med. 236:507 (Apr. 3) 1947.

[2] Zeigler, R.F., Jr.: Pre-eclamptic Toxemia of Pregnancy. North Carolina M. J. 8:655 (Oct.) 1947.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Cancer Comment

MICHIGAN HOSPITAL STUDY

During the past year the Cancer Control Committee studied the hospitals of Michigan with special reference to their facilities for the diagnosis, treatment and care of cancer patients; also for their experience with cancer as a part of their general hospital load. A similar study was made of the 1933 hospital situation by the American Society for the Control of Cancer. Changes made during the intervening thirteen years are the bases of this report.

In spite of greatly aroused interest in cancer, hospitals of Michigan are finding that their cancer load has not increased proportionately over their 1933 experience. During that year cancer patients formed 2.3 per cent of the total number of patients hospitalized—maternity patients excluded—and 2.7 per cent of such patients in the same hospitals in 1946. This static condition was doubtless due in part to the greatly increased number of noncancerous patients hospitalized in 1946 compared to 1933, a year of deep economic depression.

Twenty-eight counties in Michigan have no hospitals of twenty-five beds capacity or more. In these counties but 6.1 per cent of the population is found, and, with few exceptions, this segment of the State's population is within a reasonable distance of larger hospital facilities.

Of the 118 hospitals from which data were obtained, ninety-five admit terminal cancer patients and seventy-five accept indigent cancer patients, whose expenses are paid from public or private sources.

But twenty-two hospitals have a followup program for their cancer patients, and twenty-three hospitals have a social service department. The lack of trained medical social service personnel precludes the organization of a satisfactory follow-up program for cancer patients, a service that is of importance to the welfare of the patient and to the physician in maintaining adequate and accurate records of his patients.

Ninety-three hospitals are served by pathologists who are diplomates of the American Board of Pathology, while the pathologists serving 15 hospitals are nondiplomates. Many smaller hospitals send their surgical tissues to pathologists in larger medical centers. Only one hospital reported that it was served by an out-of-state laboratory.

Ninety-one hospitals have all surgical tissues examined. Eighteen hospitals reported that only selected surgical tissues were examined. The majority of these are hospitals of small bed capacity in which laboratory service is at a minimum.

Seventy-two hospitals are served by a radiologist who is a diplomate of the American Board of Radiology, while twenty-five hospitals reported the staff radiologist was not a diplomate. Twenty counties serving the larger population areas have deep therapy x-ray equipment in one or more hospitals within their borders. Doubtless there are similar facilities in the private offices of one or more physicians in these and other counties that were not recorded in this study.

Thirty hospitals permit any staff physician to apply radium, while in fifty-eight hospitals only the radiologist is permitted to do this.



The accompanying map of Michigan shows the location and type of service now available for the treatment and care of cancer patients. In this map the "Regional Hospital Centers" are those designated by the Michigan Hospital Survey in its report of a study made in 1946. It will be noted that in sixteen of the twenty-three proposed centers rather complete facilities are already available for service to the cancer patient.

For those interested, additional details on this study are available in the office of the Cancer Control Committee.

For surface infections . . .



Impetigo and ecthyma usually respond rapidly to topical Furacin therapy. Good results have been reported in 49 of 55 cases of impetigo[1,2,3] and in several cases of impetigo about infected wounds.[4] Ecthyma responded favorably in 19 of 24 cases.[1,2] Cure of these pyodermas is often effected within eight days. Furacin N.N.R., brand of nitrofurazone, is available as Furacin Soluble Dressing and as Furacin Solution, both containing 0.2 per cent Furacin.® These preparations are indicated for topical application *in the prophylaxis or treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin grafts. *Literature on request.* **EATON LABORATORIES, INC., NORWICH, N.Y.**

1. Downing, J. G., Hanson, M. C. and Lamb, M.: Use of 5-Nitro-2-Furaldehyde Semicarbazone in Dermatology, J.A.M.A. *133*:299, 1947 **2.** Robinson, H. M. and Robinson, H. M., Jr.: The Comparative Values of Some New Drugs in the Pyodermas, South. M. J. *40*:409, 1947 **3.** Miller, J., Rodriquez, J. and Domonkos, A.: Evaluation of Penicillin in Topical Therapy, New York State J. Med. *47*:2316, 1947 **4.** McCollough, N. C.: Treatment of Infected War Wounds with a Nitrofuran. Indust. Med. *16*:128, 1947.

Editorial Opinion

"After Doctors Are Socialized, Then Come Editors?"

"The same society that imposes socialized medical practice upon doctors will not immunize newspapermen from infection with the virus of state regimentation," warns John F. James, editor of the *Johnstown* (Pa.) *Democrat.*

The evils of mass medicine, he said, include "bureaucratic inefficiency, crass professional politics, military emphasis upon rank with its relegation of skill to a secondary position, the discouragement of initiative and enterprise, submersion of personal achievement, bureaucratic red tape, and the imposition of rigid framework of the caste system."

James charged that the reason the supporters of socialized medicine have made such gains is that the public does not know the whole story. Not all people can see mass medicine practiced from the inside, James pointed out.

"The major blame for public ignorance must rest upon the medical profession, now hiding its light beneath the hoary bushel of an outgrown ethical code which frowns upon publicity as an unforgiveable violation of the Hippocratic oath," said James.

"The medical profession today needs badly to re-evaluate a public relations policy that has failed to keep pace with its progress in the world of science and with society's progress in the field of communications," James said.

"As students of human nature, doctors are aware that frequently it is not the facts and the truth that govern, but what people believe—often mistakenly—to be the facts and the truth," James warned. He went on, then, to expound his thesis that it is up to the doctors to tell their story, so that the public can appreciate the doctors' limitations and the forces affecting their availability.

James recommended news releases from local medical associations, and abandonment of the ancient anarchy of a non-publicity ethic.—*Editor and Publisher,* April 10, 1948.

Health Act Closes Twenty-seven Factories

Only one type of artificial limb is to be made in Britain under the new Health Insurance Act.

The decision means that employes in Britain's 27 artificial limb factories will be faced with the prospect of unemployment in a few weeks' time, says Mr. E. R. Desoutter, chairman of the Artificial Limb Makers' Committee of the Surgical Instrument Manufacturers' Association.

"After July 5, the supply of artificial limbs becomes a Government monopoly, and private firms cannot exist," he stated last night.

"When we asked the Ministry of Pensions what was to happen to our specialist employes many of whom have been engaged on this work for 30 years, we were told that they would not be needed by the Ministry, and that they would be better employed in other industries concerned in the export drive.

"This is a ruthless putting out of business of many small firms. The monopoly which it will create will in a few years' time result in there being no choice of quality of products and efficiency of service.

"It is ironical that the Government, which forcibly took over our patents in 1933 should now be using them to put out of existence the companies which developed them."—*Daily Continental Mail,* Paris, France, May 25, 1948.

Retires from House of Delegates

Burt R. Shirley, M.D., Commanding Officer of Base Hospital 36, First World War, attended his last session (the twenty-eighth) as delegate of the House of Delegates at the American Medical Association meeting in Chicago, June, 1948. He represented the section on Otolaryngology. At 76 he feels he should retire. During all those years the fight against Socialized Medicine has been the most interesting from his view point.

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 47 JULY, 1948 NUMBER 7

Newer Concepts in the Diagnosis of the Glaucomas

By H. Saul Sugar, M.D.
Detroit, Michigan



WITH THE introduction of gonioscopic and chamber angle depth observations into recent considerations of ocular hypertension, it has become obvious that many of the older ideas about glaucoma need modification. These changes have been sufficient to require a broader concept of the etiology, course and even the treatment of the various ocular conditions which have, in common, an elevation of intraocular pressure.

The term glaucoma does not apply to a particular ocular disease entity but rather denotes only the presence of increased intraocular pressure. Thus, glaucoma may be one of the manifestations of a large group of ocular diseases which may be called *the glaucomas*. From the viewpoint of what constitutes an increase in intraocular pressure and, therefore, glaucoma, it must be considered as that pressure which the individual eye cannot tolerate without some damage to its integrity.

Let us consider the classification of the glaucomas as a framework for the various concepts to be discussed.

Von Graefe[12] distinguished four clinical varieties of glaucoma, namely, acute glaucoma, absolute glaucoma, secondary glaucoma, and "amaurosis with excavation of the disc" (chronic simple glaucoma). The classification in general use today is more elaborate but actually differs little from von Graefe's. It may be divided into three groups as follows:

I. Primary or idiopathic glaucoma.
  A. Congestive glaucoma (inflammatory, incompensated).
    1. Acute.
    2. Chronic.
  B. Chronic simple glaucoma (noninflammatory, compensated).
II. Secondary glaucoma.
III. Hydrophthalmos.

Absolute glaucoma is the end stage of any of the glaucomas and need not be included in any classification.

The weaknesses of the above classification lie in the lack of etiologic connotation and its failure to provide a cubbyhole for all the clinical varieties of glaucoma. One of the things which started my dissatisfaction with the above classification was my inability to classify properly the type of glaucoma which occasionally follows instillation of mydriatic drugs in patients with shallow anterior chambers and without previous ocular hypertension. Here the patient shows no evidence of vascular congestion, but the tonometric reading may be well over 60 mm. Hg (Schiötz). The condition is acute but not congestive, so it does not fit into either the acute congestive glaucoma or the chronic noncongestive glaucoma cubbyholes, although the latter is where many men have placed it.

A review[7] of a series of forty-five patients with acute glaucoma was made to determine whether the presence or absence of congestion was a justifiable criterion in the classification of glaucoma. The results of the study indicated that 95.4 per

From the Wayne University College of Medicine and Receiving Hospital, Detroit. Under a grant from the W. K. Kellogg Foundation.

cent of those twenty-four cases precipitated by mydriasis (mydriatic drugs or darkness-dilatation) were free from congestion at the onset. Of the seven with acute episodes precipitated by accommodative effort, 80 per cent started without congestion. In the group of eighteen cases precipitated by vascular engorgement, presumably involving the vessels of the ciliary body, 53.3 per cent were congested from the onset. It appeared, then, that in a majority of cases of acute glaucoma, the onset was not associated with congestion, but, after a varying period of time, the eye suddenly became congested, due, probably, to the presence of histamine-like metabolic products resulting from the poor nutrition and hypoxia associated with the interference with the blood supply by the high intraocular pressure. Congestion is only a phase into which an eye with acute glaucoma may or may not enter, depending on the precipitating factors and the duration and height of the increased intraocular pressure. Therefore, the descriptive terms congestive and noncongestive and their synonyms were eliminated from the diagnosis and only appended after it as follows:

Acute glaucoma, noncongestive phase.
Acute glaucoma, congestive phase.
Simple glaucoma, noncongestive phase.
Simple glaucoma, congestive phase.

Another weakness in the generally used classification is its tendency to give the impression that the various primary glaucomas are various stages of the same disease, so that one clinical picture may change to another and then even revert back to the original type. Beginning with Raeder[4] in 1923, there has come a separation of the two primary glaucomas of adult life into two separate entities, based on the depth of the chamber angle. This has been amply confirmed by gonioscopic evidence and by provocative mydriasis.[7]

One confusing consideration is how to classify acute glaucoma which remains unrelieved by treatment. This is still acute glaucoma which has entered a chronic phase. The term acute glaucoma is used to designate a specific entity and should be used as the diagnostic term, even though the words "chronic phase" may be appended.

The classification which I wish to present is based on an attempt to continue the time-honored terms *primary* and *secondary* glaucoma and yet maintain an etiologic viewpoint.

My first attempts at classification of the glaucomas considered only chronic simple glaucoma as primary, since this was considered the only condition whose relation to any other ocular disease was not known. Since acute glaucoma results from a known anatomic cause, it was classified as secondary. Following this classification, it was only a step further to avoid the terms primary and secondary entirely, and simply to classify each type of glaucoma according to its causal relationships. But because we do not yet know the cause of the most important glaucoma—chronic simple glaucoma—and because of usage, I have reverted in teaching to the use of the terms primary and secondary. The primary glaucomas, according to my present concept, are those which do not follow other ocular disease. In this group are included the idiopathic chronic simple glaucoma cases and those cases caused by anatomic and developmental anomalies. The latter are subdivided into the congenital glaucomas and acute (narrow-angle) glaucoma which depends on both an anatomical predisposition[7,9]—a narrow angle, usually associated with high hyperopia—and the normal continuous growth of the lens with increasing age, together with such physiologic angle-narrowing factors as accommodation, dilatation of the pupil, and congestion of the ciliary body.

The following classification of the glaucomas is suggested on the basis of the above definition of primary glaucomas.

A Classification of the Glaucomas

I. *Primary Glaucomas.*
  A. Glaucoma simplex (chronic simple glaucoma).
    Noncongestive phase.
    Congestive phase (rare).
  B. Glaucomas caused by anatomic and developmental anomalies.
    1. Congenital glaucomas.
      (a) Hydrophthalmos.
      (b) Glaucomas associated with aniridia or neurofibromatosis.
    2. Juvenile glaucoma.
    3. Acute (narrow-angle) glaucoma—due to anatomic plus physiologic angle-narrowing factors which lead to mechanical obstruction of trabecular spaces by iris. This includes acute glaucoma associated with microcornea.
      (a) Noncongestive phase — including "dilatation glaucoma."
      (b) Congestive phase—classical "acute congestive glaucoma" and the recurrent form called "chronic congestive glaucoma" in the older classification.

II. *Secondary Glaucomas.* Each may be subdivided into a noncongestive and a congestive phase. Some never enter the congestive phase.

A. Secondary glaucomas due to mechanical blockage of the trabecular spaces.

1. Obstruction by iris.
   (a) Acute secondary glaucoma due to lenticular intumescence.
   (b) Acute secondary glaucoma due to dislocation of the lens into the anterior chamber.
   (c) Glaucoma following operation for cataract—*aphakic obstructive glaucoma*—due to delayed reformation of the anterior chamber.
   (d) Glaucoma associated with essential progressive atrophy of the iris.
2. Obstruction of the trabecular spaces by particulate matter.
   (a) Glaucoma capsulare.
   (b) Pigmentary glaucoma.
   (c) Glaucoma due to obstruction by lens particles.
   (d) Glaucoma due to tumor growth.
   (e) Glaucoma due to cellular debris associated with active or healed iridocyclitis.

B. Secondary glaucomas due to lack of communication between the anterior and posterior chambers.

1. Secondary glaucoma due to seclusion of the pupil.
2. Secondary glaucoma due to total posterior synechia.

C. Secondary glaucomas probably due to overproduction of aqueous as a result of irritation of the ciliary processes.

1. Glaucoma associated with posterior dislocation of the lens so that latter touches ciliary processes.
2. Cyclitis and anterior choroiditis.

D. Secondary glaucomas due to obstruction of venous drainage.

1. Experimental and clinical glaucoma due to vortex vein obstruction.
2. Secondary glaucoma in pulsating exophthalmos.

E. Secondary glaucomas due to newly-proliferated anastomotic vessels involving the Schlemm's canal mechanism in rubeosis iridis (diabetic and arteriosclerotic) and following occlusion of the central retinal vein.

F. Secondary glaucomas resulting from trauma.

G. Secondary glaucomas associated with epidemic dropsy.

H. Secondary glaucomas associated with choroidal angioma.

A consideration of the diagnostic clinical features of each of the glaucomas would be beyond the space available in this paper. However, a consideration of the important ones, especially those which present a diagnostic problem and those about which newer concepts have arisen, will serve to describe the desired material.

Glaucoma Simplex

By far the most important of the glaucomas is the classical glaucoma simplex. The usual patient with early glaucoma simplex has no symptoms until changes in the visual fields bring the condition to his attention. Occasionally, some fogginess of vision and diminished accommodation bring him to the oculist. Less frequently, colored halos around lights and headache are complained of. In the late stages the patient complains of night blindness, contraction of the visual fields, or even interference with macular vision.

Objectively, the ocular findings in simple glaucoma depend on the stage of the disease. The earliest findings are a slight ocular hypertension and changes in the pericecal visual field, usually manifested as a vertical increase in the size of the blindspot. As the disease progresses, the field changes increase slowly, so that various characteristic changes, such a Bjerrum's sign and Roenne's step, occur. Excavation of the optic disc begins at the temporal side of the disk. As the disease progresses, the excavation of the disc increases concurrently with contraction of the field, until only a central zone about 10 degrees in diameter remains.

If allowed to continue untreated, the tension usually remains between 30 and 45 mm. of mercury (Schiötz), and the central field is finally lost. In this state of absolute glaucoma, the eye may remain painless and pale, or may rarely, after a considerable time, suddenly enter a congestive state, in which the conjunctival vessels become injected, the eye painful and the tension high. In fact, the suddenness of the onset and the symptoms may be the same as in an eye with acute glaucoma which has entered the congestive phase.

The few eyes with early simple glaucoma which have been studied in the laboratory show no abnormalities. The late stages of unoperated simple glaucoma show only the effects of increased intraocular pressure.

The diagnosis of early simple glaucoma depends on routine tonometric studies. Tactile tension esti-

mations are so notoriously inaccurate that they cannot be termed a useful substitute for the instrumental measurements. The experience of the residents in ophthalmology at the Detroit Receiving Hospital serves to emphasize the value of routine tonometry. In March, 1947, when the present glaucoma clinic at that institution was started, there were about eighteen active glaucoma patients, all in an advanced stage. Routine tonometry on all eye clinic patients of forty years of age or over led to an increase of glaucoma patients during the first nine months to 118, a high proportion of which were in the earliest stages.

Gonioscopically, the chamber angle is normal in depth in simple glaucoma, although one occasionally finds cases of simple glaucoma in which the chamber and the angle are relatively shallow. The shallowness is coincidental, since the factors leading to relative shallowing of the chamber are present in persons of the age group affected. In the late stage of simple glaucoma in which sometimes a congestive phase appears, peripheral anterior synechias may form.

The slit lamp findings in simple glaucoma are entirely negative except in the late stages when congestive episodes may have occurred. Then the evidences of congestive and atrophic changes are seen.

The provocative tests, including the water test[5,11] and the pressor-congestion test,[2] are of considerable help in the diagnosis of early cases of simple glaucoma, especially when the tonometric readings are 28 to 30 mm. Hg (Schiötz), or when the tonometric readings are lower but the history or clinical findings are suspicious. The provocative tests are significant only when positive.

In the more advanced stages the diagnosis is made on the basis of the visual fields, the tension, and the appearance of the nerve head.

Primary Acute Glaucoma

The second of the glaucomas in importance is primary acute (narrow angle) glaucoma. It is not difficult to diagnose in the full-blown congestive phase, but the differentiation in the noncongestive phase from simple glaucoma, and in the congestive phase from the secondary glaucomas, is usually difficult and of much more than academic importance. The actual onset of the noncongestive phase of acute glaucoma is hardly noticed by the patient. Blurring of vision may be noticed, especially among the younger patients. Sometimes the onset is associated with colored halos, or slight pain in the head or in the eye. These mild symptoms usually last a half-hour to two or three hours and then subside entirely, only to recur at varying intervals, becoming more frequent and lasting longer as time goes on, each attack leaving the anatomic conditions more favorable for further attacks. The circumcorneal injection associated with these episodes is slight, if any.

Occasionally the patient finds relief from his symptoms by the use of hot or cold applications, by looking at a bright light for several minutes, or by sleep.

Ultimately, one of the mild episodes will persist longer than usual, and suddenly the patient will experience marked diminution in vision, photopsia, swelling and redness of the conjunctiva and pain in the head and the eyes, often so severe as to cause nausea and vomiting. The sudden change in symptoms often awakens the patient from sleep and occurs without any precipitating factor, it being an aggravation of the previous mild symptoms and is induced by a sudden congestion of the globe, probably as a result of the accumulation of tissue metabolites within the eye when the blood supply and drainage of the intraocular fluid is impeded due to the high intraocular pressure. At any rate, the sudden aggravation of symptoms is attributable to the combination of high intraocular pressure and increased permeability of the vascular walls.

In some cases the first mild noncongestive episode of acute glaucoma is followed by the congestive phase. Of course, if treated early with miotics, even the congestive phase subsides rapidly, and if the patient does not use miotics as a prophylactic measure, it will likely recur, the disease passing again through the noncongestive phase. What has been previously called the prodromal stage of acute glaucoma is in reality the noncongestive phase of the disease.

In many patients with episodes of primary acute glaucoma there is a history of onset of the condition following nervous shock. Many authors for this reason attribute primary acute glaucoma to a nervous cause. Actually the neurovascular factors are important only as the precipitants of the angle-blocking mechanism.

Objectively, the tension may not be different in the noncongestive and in the congestive phase. It is usually very high in the latter, since the addi-

tional vascular congestion adds to the mechanical obstruction of the angle.

Shallowness of the anterior chamber is typical of this type of glaucoma and is its predisposing anatomic factor. For this reason the nonglaucomatous fellow eye of a patient who has had an episode of primary acute glaucoma may be classified as pre-acute glaucoma. The same term may be used to describe the interim of normality between episodes of primary acute glaucoma in either the noncongestive or the congestive phase.

Shallowness of the anterior chamber in this form of glaucoma is usually associated with high or relatively high hyperopia, especially during the patient's early adult life.

When vascular decompensation occurs, it produces not only chemosis of the conjunctiva but edema of all the ocular tissues. The corneal epithelium is so involved that details in the fundus are obscured. Blebs and vesicles appear on the cornea. The cornea loses its sensitivity. In the noncongestive stage, even in the presence of very high tension, the cornea is not edematous, and arterial pulsation is easily seen in the fundus.

The pupil is dilated in both phases of acute glaucoma but is irregular in the congestive phase. The dilatation, when it is not in itself the actual etiologic factor in the onset of the disease, is probably due to slight stretching of the eyeball and to the pressure effect on the nerves. In rabbits, if a needle is inserted into the anterior chamber and the pressure increased, the pupil dilates, and it contracts when the pressure is decreased. Barkan[1] suggested that the vertically oval shape of the pupil is due to anatomic narrowness of the angle above. Undoubtedly, in the congestive phase the blood supply to a few of the nerve fibers to the sphincter is affected irregularly, and irregularity of the pupil results.

The iris in the congestive phase becomes muddy and discolored. Some of the iris vessels become visibly distended. If the congestive phase persists any length of time, fine posterior synechias may form.

The nerve head in the noncongestive phase is normal. In the congestive phase, it is red but not excavated. If repeated attacks occur or if an attack persists, the disc becomes rather rapidly excavated.

Biomicroscopy reveals abnormalities only in the congestive phase or after the eye has suffered the effects of long-standing pressure as in simple glaucoma. Edema of the epithelium, blebs and vesicles are seen in the congestive phase. The contents of the anterior chamber and the vessels of the iris are difficult to see clearly in this phase. Chemical studies are of no etiologic significance but show only the results of the vascular changes.

In the noncongestive phase, gonioscopy reveals the contact between the iris and the trabecular wall. In the congestive phase, closure of the angle must be presumed, since the cornea is usually too cloudy for visibility.

In a person in whom a congestive attack is relieved spontaneously or with miotics, floating particles of pigment, irregularity of the pupil, occasional fine posterior synechias, and pigment on the posterior corneal surface are seen. Slight persistent pericorneal injection may be present. If a patient is seen for the first time after such an attack, the tension in the eye is usually below normal and an erroneous diagnosis of acute iritis may be made.

When the congestive phase of acute glaucoma has been allowed to exist without treatment, the eye eventually becomes blind and enters the stage common to all glaucomas, namely, absolute glaucoma. The eye remains injected, the episcleral veins remain dilated, vesicles form on the cornea and the iris remains muddy. Pain persists. Gradually, the vascular system adjusts itself somewhat, and the eye often becomes less painful.

Secondary Glaucomas

Of the secondary glaucomas, those due to obstruction of the trabecular spaces by iris deserve consideration as a group. They have the same mechanism as primary acute glaucoma. This is most obvious in the acute secondary glaucoma due to lenticular intumescence, which not only has the same mechanism but has the same clinical picture, except that only one eye is usually involved in the process, that any refractive error, even high myopia, may have been present, and that an intumescent cataract is present. An anterior chamber of normal depth in the fellow eye is an important differential sign. I have never seen a primary acute glaucoma with a normally deep anterior chamber in the fellow eye.

Secondary glaucoma following cataract operation has been proven clinically to be due to obstruction of the trabecular spaces by iris only since my preliminary report on the gonioscopic findings in 1940. It is important not only as proof for the fact

that obstruction of the trabecular spaces can cause a rise in the intraocular pressure in humans, but in the differential diagnosis from other glaucomas occurring coincidentally in an eye which has had an



Fig. 1. Goniophotograph of the trabecular wall shows a trabecular pigment ring (between arrows) in a case of "pigmentary glaucoma."

operation for cataract. In this type of glaucoma, the obstruction of the trabecular spaces results from delayed reformation of the anterior chamber due usually to failure to obtain tight wound closure. The clinical picture varies considerably, depending on whether it occurs early or late after the operation. When it occurs early, the eye is usually congested and painful, and may be mistaken for a postoperative inflammatory process. Late onset may be free of congestion and lead to symptom-free loss of vision as in glaucoma simplex. The diagnosis depends on gonioscopy. The etiologic factor may be relieved surgically by the cyclodialysis operation in both the congestive and the noncongestive phases.

The secondary glaucomas due to obstruction of the trabecular spaces by particulate matter are of several types, depending on the obstructing material. The diagnosis in each depends on gonioscopic examination of the chamber angle. The type designated as glaucoma capsulare[3] is associated in the exfoliation of the zonular lamella of the lens capsule. It is impossible, in this group, to be certain whether the capsular debris or the pigment granules deposited in the trabecular spaces, or both, are the cause for this type of glaucoma. A second type of secondary glaucoma associated with a marked deposition of pigment in the trabecular spaces, without capsular exfoliation, is a form of glaucoma which has never been described as an entity. I am designating it as *pigmentary glaucoma*. In 1940 I mentioned[6] a single case in a twenty-nine-year-old man with simple glaucoma in which the pigment deposition was so marked that it suggested itself as the possible cause of the increased intraocular pressure. Since then, in spite of several thousands of gonioscopic examinations, I have found only one other such case. The clinical pictures in both cases were so exactly alike and so distinctive that I am convinced that they constitute an infrequent but definite clinical entity. For this reason, a detailed description of the first case follows:

F. C., a twenty-nine-year-old man, was first seen by me on February 10, 1939. He complained of having seen colored rings about lights each time after viewing a motion picture during the previous year. His first tonometric readings were: right, 35 mm. Hg, left, 37 mm. Hg (Schiötz). His visual acuity was 20/15 each eye, corrected with −1.25 right and $-1.25+0.25\times90^{\circ}$ left. Biomicroscopically there was evidence of intraocular pigment dispersion. Pigment granules were deposited on the anterior iris surface, on the posterior surface of the cornea in the form of a Krukenberg spindle, and in the trabecular spaces to form a dense trabecular pigment ring (Fig. 1). The anterior chambers were each 3.0 mm. deep. There was no evidence of inflammation. The discs and fundi were entirely normal. The visual fields remained normal until the last ones taken on September 14, 1940, when the 1/330 white field was entirely normal, the 3/330 red field was slightly reduced on the left, and with the 2/1000 white target the left blind spot was enlarged to twice its normal size. A tension curve study was started without drops on February 10, 1939. It revealed tonometric (Schiötz) readings at 9:30 a.m. of 35 mm. right, 45 mm. left. At 12:15 p.m. the readings were 49 mm. right and 52 mm. left. Instillations of pilocarpine nitrate, 2 per cent four times daily, were started. At 3:00 p.m. the readings were 24 mm. each eye. On the following day at 10:45 a.m. the right tension was 21 mm., the left 19 mm. At 2 p.m. they were 21.mm. each eye. On the next day at 9:30 a.m. they were 19 mm. right and 22 mm. left. On continued pilocarpine therapy, the tension remained normal most of the time but varied between 37 and 18 right, and 37 and 15 left, until November 16, 1940. Seven years later, on December 15, 1947, the corrected visual acuity was still 20/20 with each eye. The tonometric readings were 43 mm. right and 28 mm. left, under 1 per cent pilocarpine three times daily. The visual fields showed only a 5° lower-nasal-field loss in the left eye (1/330 mm. target).

The second case* was that of a young man of thirty-three. The clinical picture was exactly the same as the first. His visual acuity was 20/20 each eye with $-3.25+1.75\times10$ right and $-2.50+1.25\times1.75$ left. The anterior chambers were deep. The fundi and visual fields were normal. The picture of pigment dispersion was evidenced

*This patient was seen by me through the courtesy of Dr. Fleming A. Barbour of Flint, Michigan.

by a Krukenberg spindle and a trabecular pigment ring. The response to homatropine was unfavorable, raising the tension to 50 mm. Hg each eye. On pilocarpine, the readings varied between 25 and 28 mm.

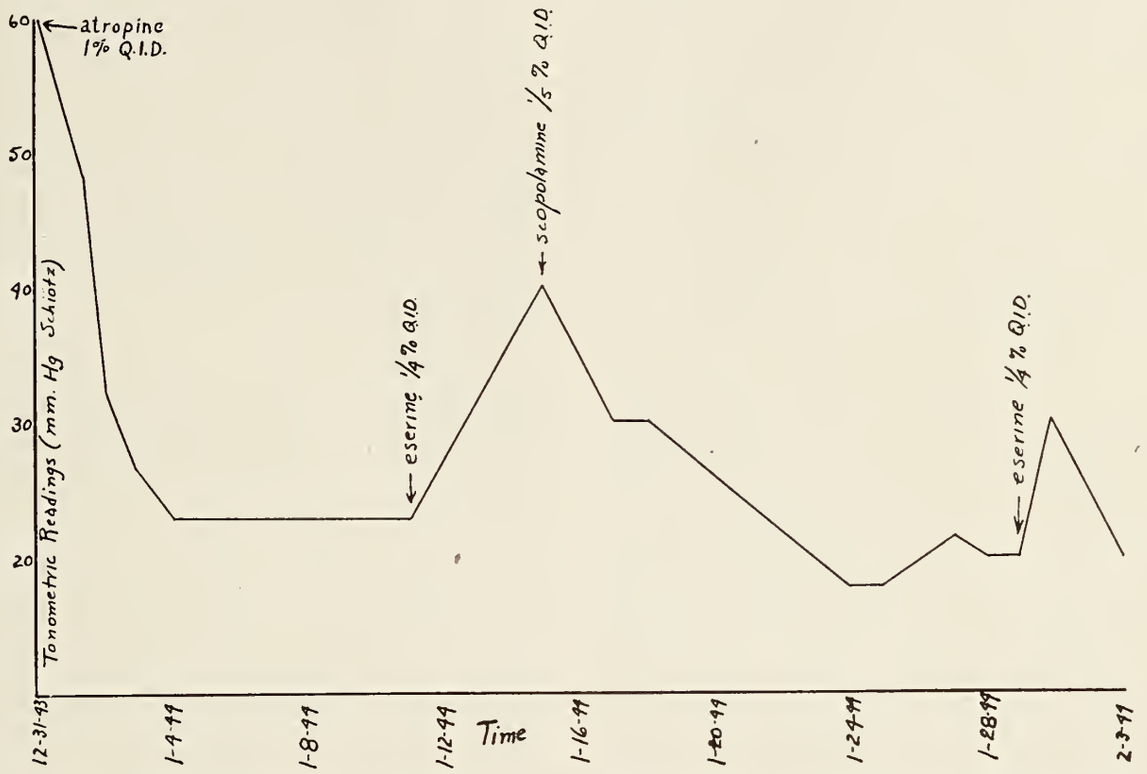


Fig. 2. Graphic representation of the effect of cycloplegics and miotics in the treatment of cylitic secondary glaucoma.

Secondary glaucoma due to obstruction by cellular debris in the angle is difficult to differentiate from simple glaucoma when the antecedent iridocyclitis is completely inactive. Only the history of a previous iridocyclitis and the gonioscopic and biomicroscopic findings suggest the possible cause. If the condition is and remains unilateral, the diagnosis is more probably correct. In this case the treatment is exactly the same as that for simple glaucoma, both medically and surgically.

The secondary glaucoma associated with cyclitis or anterior choroiditis is probably due to an overproduction of aqueous and is usually temporary, lasting only as long as the irritative inflammatory process persists in a relatively quiet form. It is interesting that early in these inflammatory processes, when the eye is congested, the intraocular tension is usually lower than normal, as in ordinary acute iritis. This is presumably due to a general vasodilation involving the iris and ciliary body. As the inflammatory process appears to subside and the eye becomes relatively paler or completely white, the intraocular pressure rises. Deposits on the posterior corneal surface increase, even though evidence of increased protein in the aqueous may decrease or even be biomicroscopically absent. The diagnosis is important in that the intraocular pressure responds favorably to atropine or scopolamine and not usually to miotics. This type of response was well shown in the following case:

S. V., a twenty-five-year-old man, was first seen by me on December 31, 1943. He had been entirely well until July, 1943, when he began to notice fogginess of vision, first in the left eye and later in both eyes. Examination revealed a bilateral chronic granulomatous iridocyclitis. The visual acuity was 20/30 right, 20/20 left. The tonometric readings were 21 mm. Hg (Schiötz) right and 60 mm. left. Both eyes were rather pale. Atropine, 1 per cent, was instilled into the left conjunctival sac three times daily. The response to cycloplegics was favorable, to eserine unfavorable, as shown in Figure 2. The tension stayed normal from February 3, 1944, until a recurrence of the iridocyclitis appeared in June, 1946. This episode responded in a similar manner to scopolamine.

One other secondary glaucoma will be considered since some new thoughts concerning it have appeared. This is the secondary glaucoma associated with rubeosis iridis, and following occlusion of the central retinal vein. From the viewpoint of mechanism both of these are exactly the same.[8] The chamber angle early is open and shows the

same new-formed vessels lining the angle and penetrating the angle wall. Later the angle becomes blocked by adhesion between the iris root and the trabecular wall. The earliest case of this type I have seen was in a patient with a blind painful glaucomatous eye with diabetic rubeosis iridis, in whose other eye very localized small areas of rubeosis became evident near the pupil border and in a portion of the angle as the tension rose in that eye to 36 mm. Hg (Schiötz). The angle was entirely open. The new-formed vessels lining the small areas of the angle could be seen penetrating the trabecular wall, presumably to anastomose with Schlemm's canal. The occurrence of this condition in an eye with poor nutrition and hypoxia, as a result of severe vascular disease, suggests a causal relationship. The formation of new-formed vessels is stimulated, causing anastomoses with Schlemm's canal and in some way destroying the usefulness of this mechanism. The treatment of this form of glaucoma is cyclodiathermy for the pain, or enucleation. The presence of the new-formed vessels may lead to spontaneous hemorrhages (hence the term hemorrhagic glaucoma). When surgical treatment is attempted, these vessels nearly always preclude success.

Occasionally one finds a combination of two forms of glaucoma in the same patient. This has been described as mixed glaucoma.[10] Mixed primary acute glaucoma and glaucoma capsulare occur. Simple glaucoma and secondary glaucoma following central vein occlusion have appeared together. There may even appear a superimposition of primary acute glaucoma coincidentally on the background of a simple glaucoma, though this is extremely rare.

Summary

A new classification of the glaucomas based on clinical evidence is suggested. The classification is arranged so as to include the same groupings into primary and secondary glaucoma which usage has made universal.

The diagnostic features of those forms of glaucoma where newer concepts have appeared, and of one form not hitherto described as an entity, are presented. The latter is designated as *pigmentary glaucoma.*

Emphasis is placed on routine tonometry in all patients forty years of age or over to make early

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Osteochondritis Dissecans and Osteochondromatosis

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OSTEOCHONDRITIS dissecans and osteochondromatosis are two affections of joints that are uncommonly encountered. These closely allied but distinct pathological entities are listed among the various conditions producing free bodies within joints.

Osteochondritis dissecans is a noninfectious sequestration of a segment of subchondral bone within a joint. It is a disease primarily of young adults, with males predominating in incidence, three to one. Eighty-five per cent of the cases are of the knee joint. The elbow, hip, ankle, shoulder, metatarsal-phalangeal joints, carpal scaphoid and lumbar vertebra have been reported as affected by this entity. Involvement is usually unilateral although bilateral cases have been observed. Seven cases have been critically studied in this hospital.

There has been much discussion in the literature concerning etiology since Munro in 1726 first noted a loose body in the knee joint with a defect in the medial condyle of the femur. He attributed this to external trauma.

Contributions adding to the knowledge of this entity have been made by Broca in 1854, Paget in 1875, and Koenig who in 1905 coined the term now employed to designate the condition. Axhausen, in 1912, suggested that blood vessels were damaged from repeated impaction of opposing articular surfaces with resultant necrosis. A zone of absorption was said to follow, with a gradual separation and extrusion of the dead portion of the articular surface.

In 1917, nine cases were recorded by Brackett. In most of these, the patients knelt at their work. It is interesting to note that in one of these case presentations, the sequestrated body had become attached to the posterior cruciate ligament. Kappis, in 1920, advanced the theory that detachment occurred from repeated impaction between articular surfaces of femur and tibia, thus repeating in effect Axhausen's ideas. Kappis considered that torsion was a factor. Freiberg, in 1932, stressed

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the role of a large tibial spine in several of his cases which he thought may have entered into the number of factors necessary to produce the condition. (Study of the lateral projections of cases in this hospital, compared with anatomical material, indicated that the site of the lesion occurred in a plane anterior and medial to the intercondyloid eminence. Impingement in these particular cases seemed anatomically improbable.)

In 1924, Phemister produced evidence seemingly to disprove the purely traumatic origin of loose bodies. He cited the behavior of chip fractures which almost never remain free in the joint, but become attached to synovial membrane. They are, as a rule, absorbed within a few months. Experimentally, pieces of bone and cartilage chipped off and reinserted into their beds became reattached in nearly all instances. Testing Axhausen's theory, Phemister and others do not report evidence of vascular occlusion. Sections demonstrated bone and cartilage in the living state, although bony separation was complete or almost so and had existed as such for a considerable time before removal for examination. Slow necrosis does occur when the body has been extruded into the joint. Experimenting with radium, Phemister found that instead of the tissue sloughing, reparative changes occurred, with creeping substitution of the dead portion by new bone. He concluded that the process is the result of non-union following incomplete or subchondral fracture between cartilage and bone, or through bone, with subsequent severance of the cartilaginous bridge either by trauma or absorption.

Conway, in 1937, pointed out the insensitiveness of cartilage and underlying bone. In the case of the knee joint, he thought that trauma could be transmitted through the patella, and, acting through the cushion of the articular cartilage, could split off, fissure, or chip, a portion of the femoral condyle, thus initiating the process. Freund, in 1939, held that the condition in the hip joint is not a clinical entity but the result of a secondary complication during the period of reorganization which primarily aims at complete substitution of a more or less extensive area of epiphyseonecrosis. Ribbing, in 1944, postulated the presence of a superficial accessory nucleus of bone.

It should be noted that Knaggs discussed bacterial embolism as a possible cause. Endocrine disturbances such as hypothyroidism are occasionally said to be associated with changes in the articular cartilage similar to osteochondritis dissecans. To date, there are no known reasons why the ends of long bones are so consistently involved. Though there are numerous theories as to the etiology of osteochondritis dissecans, most authors are willing to admit that trauma does play a role in the development of this condition.

Osteochondromatosis is a somewhat more rare condition involving the irritated synovial membrane with the formation of osseocartilaginous structures (synovial chondrification). These may be attached to the villous tips, lie free within the joint or be extruded into periarticular tissues.

The onset of the disease apparently occurs during late childhood or early adulthood, although the diagnosis may not be known until later in life. It is a disease primarily of males. The knee joint is most commonly affected, the elbow second in frequency. Bunne reported a total of eighty cases appearing in the literature up to July, 1929. One of these was of the hip joint to which Bunne added two cases, both in men over sixty years of age. Rixford added one of the knee in 1930. Colonna presented four females with involvement of the knee joint in 1931. Vincent and Vincent were able to collect 111 cases in the literature in 1931. H. B. Macey added one case adjacent to the psoas tendon in 1934. Jalet in 1937 discussed one of the hip, secondary to osteochondritis juvenalis. Freund presented three cases of "chondromatosis of the joints" in 1937, one of the shoulder and two of the hip. Wiberg, in 1938, and Sato, in 1939, are referred to in the literature as discussing osteochondromatosis of the hip joint, but no mention of case reports is made. Wilmoth in 1941 presented a series of nine cases; six of these involved the knee joint, two of the elbow and one of the hip. Apparently 125 cases have been reported in the literature of osteochondromatosis, seven of which involved the hip joint. It is of interest that only three cases in this series had involvement of two joints. One of the three cases studied in this hospital had involvement of the hip joint, one had bilateral involvement of the knee joints.

Attention was called by Laënnec, in 1813, to the relationship between loose bodies and synovial membrane. He believed that they arose from the subsynovia. Sir Benjamin Brodie, in 1836, thought that the loose bodies arose from the external surface of the synovial membrane. Lexer, in 1907,

suggested that they developed from embryonal rests. Whitelocke, in 1914, believed that fibrous tags hanging from the synovial membrane became cartilaginous. He thought this change could occur as a result of inherent embryonic potentialities, implying metaplasia. Henderson, in 1917, and Henderson and Jones, in 1923, considered osteochondromatosis to be a nonmalignant neoplasm. Little weight was given to the purely traumatic theory of origin. Jones offered a case study in 1927 as definite support for the theory that synovial chondromatosis is a neoplastic manifestation. The formation of cartilage in this case followed closely the embryonic method of development of cartilage from undifferentiated connective tissue.

Boehm, in 1928, reviewed the four principal theories of the cause of osteochondromatosis: (1) infectious, (2) traumatic, (3) embryonic, and (4) neoplastic. He concluded that osteochondromatosis is similar in nature to a benign tumor and that trauma cannot be excluded as a factor in its origin. Rixford, in 1930, was of the opinion that trauma seems unlikely as a specific single cause. Geschickter, in 1930, considered that trauma probably functioned in disturbing precartilaginous connective tissue in the synovial membrane and that there is a definite connection between osteochandromatosis and normal developmental processes in the tissues. Freund, in 1937, stated that the process is similar to that of myositis ossificans—a metaplastic hyperplasia of connective tissue. Here again are numerous conjectures in relation to the etiology. The majority of opinions however seem to favor a metaplasia of abnormal synovial membrane (hypertrophic villous synovial membrane) probably initiated by trauma.

Anatomical Considerations and Pathology

Osteochondritis dissecans occurs most frequently in the knee joint, on the anterolateral margin of the medial condyle. The structural arrangement of the femur is such that the longitudinal trabeculae gradually assume curved paths near the distal end of the femur and end perpendicularly with respect to the articular surface at every point. The lower end of the femur transmits loads carried through a hinged joint. In addition to the primary hinged action of the joint, rotation occurs to lock the joint and complete extension. This produces a grinding force due to the pivoting of the tibia on the extended femur.

A similar grinding force occurs in the elbow, directed against the capitellum of the humerus as the arm is thrown forward from the cubitus valgus position into the extended position. Bennett describes this entity involving the elbow in young professional baseball pitchers as an occupational disease. King and Richards suggest a similar action, i.e., a grinding rotational force in relation to the development of osteochondritis dissecans of the superolateral aspect of the caput femoris.

Crysler and Morton described six cases of the disease in the supratrochlear septum of the humerus. Ross reported a similar case and raised the question of the loose body gravitating to the spot and becoming pressed into the septum.

Ray and Coughlin demonstrated involvement of the articular surface of the talus in fourteen cases.

There is an explanation for the susceptibility of these areas to trauma and the possibility of the separation of a loose body. In the embryo, permanent compact bone is laid down by the perichondrium and subperiosteally. This cortical bone plays a prominent part in the healing reaction after injury. The cancellous bone of the epiphysis is meagerly supplied by the nutrient vessel in long bones. The major vascular supply being from vessels anastomosing around the joint, sending branches into the periosteum and thence into the haversian systems of the epiphyseal region. Lexer demonstrated that these vessels pursue a periosteal and transcortical route with an apparent deficiency of blood supply in the lateral surface of the medial femoral condyle. It is not unreasonable to assume, therefore, that the sites of osteochondritis dissecans are not mere chance, but represent areas with a relative vascular deficiency in which non-union may be more apt to occur.

Osteochondritis Dissecans.—On exposing a joint affected by osteochondritis dissecans, the earliest gross pathological change noted is a faint whitish line of demarcation in the cartilage. It is seen most commonly and characteristically on the anterolateral surface of the medial condyle of the femur (Table I, Cases 1 and 2). On incising the cartilage, the underlying bone may be found separated from its base in whole or in part. Fibrous tissue lines the defect. As the process develops, the overlying cartilage may be fissured or split. After separation of the subchondral bone from its base, degenerative and regenerative changes occur,

whether lying in its bony bed or free within the joint (Table I, Cases 3 and 4). Degenerative changes may be slight during the period of attachment. Proliferative changes consist mainly in covering the surface of separation with fibrous tissue, which may become fibrocartilaginous in part, with a thin outer layer of fibrous tissue resembling perichondrium.

The loose body may be retained in the defect for a time by bands of tissue. Eventually these give way, permitting the loose body to migrate into the joint. The body may cause locking and further damage to the articular surfaces by impingement, or may become attached to the synovial membrane in a recess of the joint. As a result of attachment, the fragment may be absorbed (Table I, Case 5), or revascularization may occur with possible growth. There may be a transition to osteochondromatosis.

Bodies that have been loose for a considerable period of time undergo a slow type of necrosis and a change to fibrocartilaginous bodies. On section, little of the original structure may present itself.

A final stage in untreated osteochondritis dissecans is osteoarthritis which may progress to ankylosis. This is particularly a sequel to cases involving the elbow (Table I, Case 7).

Synovial changes are minimal in the retained phase. In the sequestrated phase, due to irritation, there may be patches of hyperplasia and corresponding increase in synovial fluid. In the attached phase, there is localized hyperemia and hyperplasia. This may be the only finding in case of absorption, or the synovial membrane may have returned to a more normal state. The findings in the phase of osteoarthritis are those of synovial adhesions, patches of hyperplasia and hyperemia, depending on the degree of irritation.

Primary changes in the articular surfaces, other

TABLE I. OSTEOCHONDRITIS DISSECANS

Case	Roentgen Findings	Nature of Body at Surgery	Pathologic Findings
1.	Defect in anterolateral surface, medial condyle, left.	Retained	Articular cartilage and cancellous bone.
2.	Defect in anterolateral surface, medial condyle, right.	Retained	Articular cartilage and cancellous bone.
3.	Defect in anterolateral surface, medial condyle, right. Crescentic density above patella.	Loose	Articular cartilage and cancellous bone, "slow necrosis".
4.	Defect in anterolateral surface, medial condyle, left. Three bodies, calcium density.	Loose	Articular cartilage and cancellous bone, "slow necrosis."
5.	Defect in anterolateral surface, medial condyle, right. Body of calcium density medial to patella.	Absorbed two months later.	Defect in medial condyle lined with fibrous tissue.
6.	Ununited fracture (?), tip, lateral malleolus, right.	Loose	Articular cartilage and cancellous bone.
7.	Mottling of capitellum, right, in 1940. Osteoarthritic changes and loose bodies, 1947.		

TABLE II. OSTEOCHONDROMATOSIS

Case	Roentgen Findings	Nature of Body at Surgery	Pathologic Findings
8.	Defect in anterolateral surface, medial condyle, left.	Synovial chondrification	Fibrous tissue, cartilage, and osteoid tissue. Defect in condyle lined with fibrous tissue.
9.	Three large areas of mottled density, right knee joint.	Loose	Fibrous tissue, cartilage, and osteoid tissue.
	Three areas of mottled density, left knee joint.	Loose	Fibrous tissue, cartilage and osteoid tissue.
	Bilateral fabella.		
10.	Multiple facetted opacities of mottled density, left hip joint.	Loose and attached	Fibrous tissue, cartilage, osteoid tissue. Attached bodies showed vascular marrow spaces in the osteoid tissue.

than the defect, depend on locking and impingement.

Microscopic changes parallel the gross findings. In the retained phase, the cartilage and bone cells

future skeleton. Its derivatives may retain the power of cartilage formation throughout life.

As a result of repeated traumatic irritation, hyperplasia of the synovial membrane may occur.

TABLE III. OSTEOCHONDRITIS DISSECANS

No.	Hosp. Case No.	Age Sex	Joint	Duration of Complaints	Chief Complaints	History of Trauma	Management
1.	74794	19 M	Left knee	1 year	Soreness	Yes	Surgical
2.	77903	16 M	Right knee	4 years	Soreness	Yes	Surgical
3.	85679	26 M	Right knee	4 years	Locking, aching	Yes	Surgical
4.	83511	48 M	Left knee	25 years 1 year	Aching, locking	Yes	Surgical
5.	77653	20 M	Right knee	6 months 2 months	Soreness, locking	Indefinite	Surgical
6.	82232	21 F	Right ankle	8 months	Soreness, swelling	Yes	Surgical
7.		18 M	Right elbow	5 years prior to initial visit	Soreness, stiffness	Yes	Consultation only

Average age: 24 years. Average age at onset: 18 years.

TABLE IV. OSTEOCHONDROMATOSIS

No.	Hosp. Case No.	Age Sex	Joint	Duration of Complaints	Chief Complaints	History of Trauma	Management
8.	79509	17 M	Left knee	1 year	Swelling, soreness	Yes	Surgical
9.	65242	46 M	Both knees	12 years	Locking, soreness, swelling	Yes	Surgical
10.	71229	26 M	Left hip	8 years	Locking, soreness, swelling	Yes	Surgical

Average age: 29 years. Average age at onset: 22 years.

are viable. Patches of calcification may be found in the cartilage. The marrow spaces of the underlying bone may be filled with acellular connective tissue. Proliferation of fibrous tissue occurs along the zone of demarcation. Peripheral areas immediately following separation of the body, appear ragged and moth-eaten. A body free in the joint, deprived of all vascular supply, undergoes a slow type of necrosis. No inflammatory reaction is noted. Vascular changes were not found in any of the sections studied. Multiple foci of calcification are often present.

Osteochondromatosis.—It is to be remembered that bones and joints begin their differentiation from a single type of mesenchyme. This tissue is represented in the precartilaginous state of the

Metaplasia may then supervene as an individual reaction. Minute beads of cartilage are formed in the tips of relatively undifferentiated connective tissue of the villous synovial membrane. Formation of osteoid and eventually osseous tissue in the cartilage may occur in due course of time (Table II, Cases 8, 9, and 10).

There may be changes suggestive of the coexistence of osteochondritis dissecans and osteochondromatosis (Table II, Case 8). Liebman and Iseman, and Geschickter have suggested that loose bodies may become attached to the synovial membrane and proliferate similarly to osteochondromatosis.

On exposing a joint affected by this condition, the synovia is somewhat increased in amount and viscosity. The underlying synovial membrane is



Fig. 1. Defect in the anterolateral surface of the medial condyle, consisting of an area of increased density bordered by a narrow zone of decreased density.



Fig. 2. Cresentic patch of increased density lies in the suprapatellar space. The defect in the medial condyle is seen as a slight irregularity in the surface.

hyperplastic. Patches of hyperemia are usually present. There may be papillary osseocartilaginous or cartilaginous projections with fibrous pedicles. Free bodies may present themselves. These vary in size from tiny pearl-like structures to large masses of dull whitish hue, 6 or 7 centimeters in diameter. Unopposed surfaces, particularly in bodies attached by a pedicle to the underlying membrane, may even assume a mulberry or cauliflower-like appearance.

The articular surfaces of the joints involved, while basically normal, bear the imprint of loose bodies which have been caught and "locked." In consequence, there may be areas of chondromalacia and exfoliation, with resultant defects in the articular cartilage. Occasionally an excrescence of an osseocartilaginous nature is found at the juncture of bone and cartilage (the synovial margin).

Microscopic sections reveal an outer layer of connective tissue cells, perhaps the remnant of the stratum synoviale. Beneath this is a fibrous tissue layer, encapsulating fibrocartilage and cartilage. Areas or even layers of calcification may be found, or the interior may contain osteoid or osseous tissue. There is a marked tendency to the development of osseous tissue even in the tiny cartilagious papillae on the synovial membrane. Thus there is a characteristic transition from without in: fibrous tissue to cartilage to bone. The bone may be differentiated into cortical and cancellous bone. Marrow spaces may be present. In attached bodies these may be filled with numerous small blood vessels, fibroblasts, fatty tissue, and blood elements. More commonly, the lamellae of bone which form are free of haversian canals and marrow. The cartilage in free bodies is nourished by the synovia, whereas the osseous portion may become necrotic. Free bodies may receive sufficient nourishment to increase in size. Phemister once said that this condition afforded the best example of tissue culture *in vivo* that he was acquainted with.

Symptomatology

A clinical history in both entities will elicit a story of episodes of aching or soreness about the joint. Trauma may or may not be alluded to as the instigator of the symptoms.



Fig. 3. An oblique view to demonstrate irregularity of contour of the capitellum and mottling of the subchondral bone. There is a loose body present in the interosseous space just distal to the radial head.



Fig. 4. Cartilage-covered osseous body at the tip of the lateral malleolus, impinging on the joint between the talus and calcaneous.



Fig. 5. Fifty osseocartilaginous bodies removed from the left hip joint (Case 10). The size varied from 0.5 cm. to 7.0 cm. in diameter.

With sequestration of a body or detachment of an osteochondromatous body, the "mouse" may be discovered by the patient on palpating the parapatellar bursae in knee involvement. Locking occurs in the presence of a free body, and the patient is unable to fully flex or extend the joint. A particular maneuver may free the body, allowing free range of motion. Little or no change about the joint may be described by the patient. This is more characteristic of osteochondritis dissecans than of osteochondromatosis.

The symptoms of osteochondromatosis are those of a mildly sore joint with episodes of aching and swelling of the joint. Bogginess may occur. Locking may be complained of, and the patient may have discovered one or more loose bodies on palpation. A grinding or velvety crepitation on motion may be described and can be verified by palpation of the joint during active motion. Muscular atrophy of slight degree may be masked by the joint swelling. Moderate atrophy has been reported.

Roentgen Findings

The clinical diagnosis or suspicion of the existence of either of the two conditions must be verified by roentgen examination.

Osteochondritis Dissecans.—In the anteroposterior projection one sees in the early or retained stage a defect in the articular surface. This consists of an area of increased density bordered by a zone of decreased density resembling a ring lying on contrasting material (Fig. 1). With progression of the disease, the shadow of increased density will appear to be lying in the joint space as if displaced out from the articular surface. With complete separation of the body, the defect remains as a landmark even though its outlines may



Fig. 6. Two large oval bodies of a mottled calcium density are noted in the suprapatellar space and one in the intercondyloid fossa of the right knee joint. Note the fabella which was bilateral in occurence (Case 9).



Fig. 8. Lateral roentgenogram shows diminution in the joint space and irregularity of the articular surfaces, indicative of osteoarthritis of the elbow joint.

soften and blend into its background with the passage of time (Fig. 2). The loose body may then be visualized, if present, in any portion of the joint, usually seeking a pocket in the synovial



Fig. 7. Multiple loose and attached bodies of mottled calcium density in the left hip joint.

membrane. It may become fragmented and visualized as several small bodies.

In the knee joint, a defect in the anterolateral surface of the medial condyle is characteristic. In the hip joint, the typical location is on the superolateral aspect of the articular cartilage of the femoral head above the round ligament. The osteochondritic focus is denser than the underlying femoral head and rests directly upon it. In the elbow joint (Fig. 3), the capitellum is most frequently involved. In the ankle joint (Fig. 4), visualization of both loose body and articular defect may be difficult. Mensor reports the use of tomography in picking up these defects. Oblique studies, in addition to routine anteroposterior and lateral views, throw into relief any defects in the talus.

Osteochondromatosis.—Roentgenograms reveal circumscribed bodies of variable density in the joint area. These may vary in size from minute points to areas five to seven centimeters in diameter (Fig. 5). These may be few in number (Fig. 6) or many (Fig. 7). They are not attached to the underlying bone, but lie within the joint or in the soft tissue adjacent. Bodies have been seen outside the joint space suggesting extrusion. The point of origin of these bodies is not detected as an articular defect. Usually the bodies are much more numerous and, at times, more mottled than the shadow seen in osteochondritis dissecans.

Treatment

In both conditions, surgical intervention is the treatment of choice. There have been cases of osteochondritis dissecans responding to conservative treatment (immobilization). Strange's case, a child of four years, resolved after three and one-half months of immobilization in plaster-of-Paris cast. Contrarily, the process has progressed in several other instances treated by immobilization.

Arthritic changes have occurred with non-operative care (Figs. 3 and 8). In the cases operated upon at this hospital, no recurrence or permanent disability has occurred. We know that immobilization for two or more years may be necessary to secure healing of a Legge's disease. It is possible that osteochondritis dissecans of the hip and knee in the retained phase might respond to adequate immobilization; however, economic factors necessitate a more immediate result. Surgical intervention offers a rapid relief of the condition and an early return of the individual to a productive capacity. It has often been demonstrated that progressive arthritic changes, secondary to the condition, are obviated by early surgical removal of the process.

Conservatism plays little part in the treatment of osteochondromatosis, as surgical removal is the only means of curing the condition. It is noteworthy that no effort is made to dig out loose bodies that have been extruded into the adjacent soft tissues from the joint unless they interfere with function or cause pressure on nerves or vessels. A partial synovectomy is usually indicated when the synovia shows definite changes. Case 9 from this hospital, with bilateral osteochondromatosis of the knee joint, has been followed for seven years with no complaints referable to the knees, or no recurrence of the condition.

Summary

Two relatively uncommon clinical entities, osteochondritis dissecans and osteochondromatosis have been discussed. Both conditions produce free bodies within a joint. Theories of etiology, laboratory studies, experimental work and clinical observations have been reviewed and correlated with the findings in our own cases.

The consensus points to trauma playing a definite role in producing noninfectious sequestration of subchondral bone from an articular surface with a deficient nerve and vascular supply in the case of osteochondritis dissecans. Trauma is apparently a predisposing factor in initiating the metaplastic process of synovial chondrification resulting in osteochondromatosis.

Careful roentgen studies are mandatory for exact diagnosis.

A careful review of the literature and a critical analysis of ten cases managed at this hospital point to the fact that surgical removal of the free bodies within a joint offers the more satisfactory method of treatment.

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(Continued on Page 812)

Benign Pulmonary Histoplasmosis

Familial Incidence

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HISTOPLASMOSIS, OR reticulo-endothelial cytomycosis, was first clearly described by Darling[4] in 1906 as a protozoan infection producing pseudo-tubercles in the lungs and focal necrosis in the liver, spleen, and lymph nodes. In 1913, Da Rocha Lima[5] concluded the organism was a fungus. Hausmann and Schenken[7] described a unique infection with a yeast-like organism in 1933. Amolsch and Wax[1] in 1939 described fatal histoplasmosis in an infant with otitis. In 1943, Parsons and Zarafonetis[12] reported the autopsy findings in a twenty-year-old colored male, and in 1945 reviewed seventy-eight cases then in the literature.

In the same year, Morgan[10] summarized the then known facts about the disease.

Recently, workers in the public health field, such as Palmer,[11] Emmons et al,[6] Christie, and Peterson[3] have made extensive surveys of large segments of the population who have pulmonary calcifications with negative tuberculin tests, and who are in apparently good health. Since tests with a diluted extract of histoplasmin show varying degrees of sensitivity, it is considered that these people have been infected with histoplasmosis and have recovered.

Etiology

Histoplasmosis has been defined as a generally fatal systemic disease of the reticulo-endothelial system, produced by minute round, oval, or crescent-shaped fungi with a thick highly refractive capsule. Apparently in man the organism, Histoplasma capsulatum, is found as separate yeast-like cells, but when cultured, mycelial threads and budding occur.[9]

Epidemiology

It has been found throughout the world except in the frigid zones.[10] The incidence is higher in young children and in those past fifty years. It is three times as common in males as in females according to Morgan.[10]

Monkeys can be successfully inoculated, and dogs may harbor the organism.[9]

Benign pulmonary calcifications, considered due to histoplasmosis, have been found in many people living near or on the Western Appalachian plateau and in states bordering the Mississippi river slopes.[3] The cases which are to be described later have resided in Salinas, Tennessee.

Symptomatology

In children, diarrhea, abdominal discomfort, irritative or ulcerative lesions of the skin, enlarged peripheral lymph nodes, chronic cough, low grade fever, and weight loss may occur.

Symptoms of the so-called benign cases have rarely been described in the literature.

Morgan[10] divides infected patients into five groups:

1. A pulmonary type with cough and symptoms of a cold, occasionally associated with tuberculosis, and showing massive infiltrations with areas of focal necrosis, and multiple foci resembling tubercles, in the lungs.

2. Generalized or regional lymph node involvement.

3. Ulcers of the mucous membranes and skin.

4. Fever, lassitude, hepatomegaly, splenomegaly, anemia and leukopenia.

5. A protean type with arthritis, sore throat, hoarseness, or gastrointestinal symptoms.

Differential Diagnosis

It has been confused with tuberculosis, kala azar, noma, aleukemic leukemia, influenza and virus pneumonia.

The lesions, in chest x-rays of the pulmonary cases, may simulate miliary tubercles.

Prognosis

Ziegler and many other workers repeatedly state that it is highly lethal, but many cases in the Appalachian mountains and in the Tennessee Valley, with pulmonary calcifications, positive histoplasmin tests and negative tuberculin reactions, are now believed to be benign infections.

Presented at the medical staff conference of Providence Hospital, February 18, 1947.

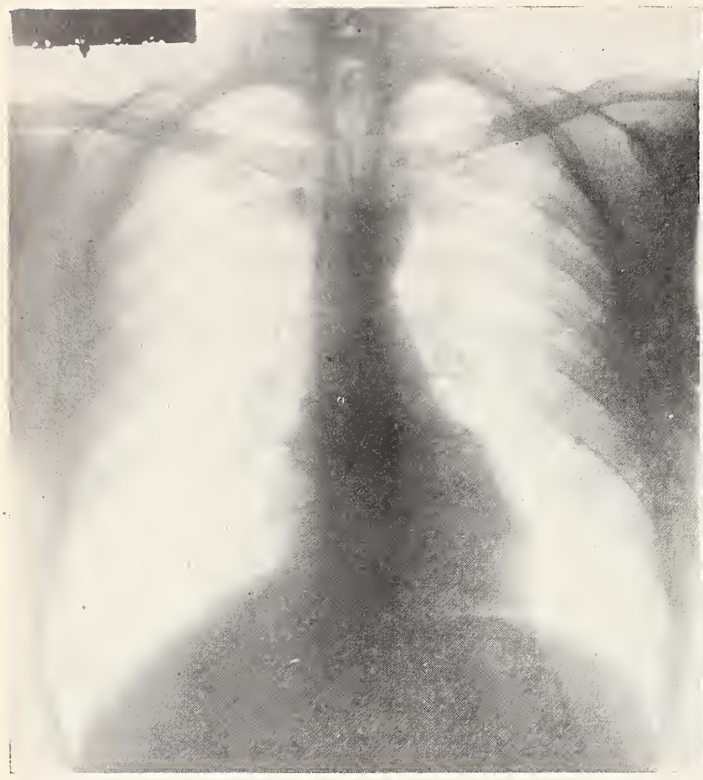


Fig. 1. Chest x-ray of Mr. R. S. was considered normal except for two discrete calcified nodes in the base of the left lung.



Fig. 2. Chest x-ray of Mrs. L. S. showed many calcified hilar glands.

Family Case Study

The S. family consists of the father, Roy; mother, Lillian, and three daughters: Helen, aged sixteen; Anna, aged fifteen; and Betty Jean, aged thirteen years. The parents were residents of Tennessee until 1928 when they came to Detroit.

Mr. Roy S., aged forty-four, had no complaints when first examined in 1944. He had had hay fever for the past year (1944) which started in July and stopped when a frost came. On October 14, 1944, an x-ray of his chest (Fig. 1) was considered normal except for two small discrete calcified nodes in the base of the left lung.

On November 5, 1945, he stated that he had been in the Cumberland Valley in Tennessee for two weeks during the previous July. His histoplasmin test showed a very slight reaction (0.5 cm. in diameter) with no induration or itching. An x-ray of his chest on February 2, 1947, showed no changes.

Mrs. Lillian S., aged thirty-six, on December 18, 1944, complained of a hacking cough for three months with a low grade fever, and felt very tired. An x-ray of her chest (Fig. 2) revealed many healed calcified dense hilar glands. A few discrete ovoid lesions were seen in the right infraclavicular region.

Her blood count on December 28, 1944, revealed the following: hemoglobin, 87 per cent, 14.5 gm.; red blood cells, 4,760,000; white blood cells, 12,000; neutrophiles, 64 per cent; small lymphocytes, 34 per cent; eosinophiles, 2 per cent. Her temperature on that date was 99.2°. About a fortnight later, on January 2, 1945, her cough was gone and she was feeling well. Clinical examination

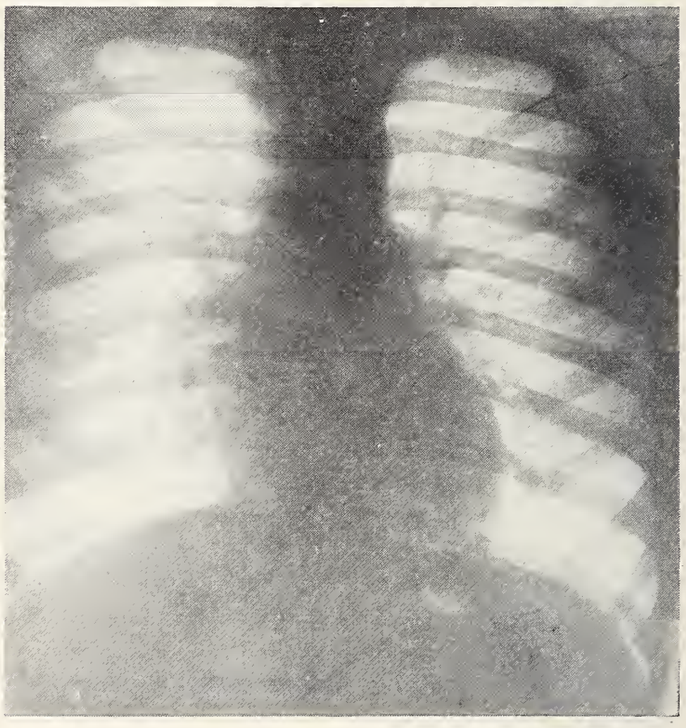


Fig. 3. Chest x-ray of Anna S. showed calcified masses in the right lung and some tiny doughnut-like areas near the right cardiac border.

at that time was negative, including a normal temperature.

On November 5, 1946, she stated that she had been in the Cumberland Valley in Tennessee for two weeks in July of 1945. A histoplasmin test done at that time showed a very slight reaction (.8 cm.) with no edema or induration.

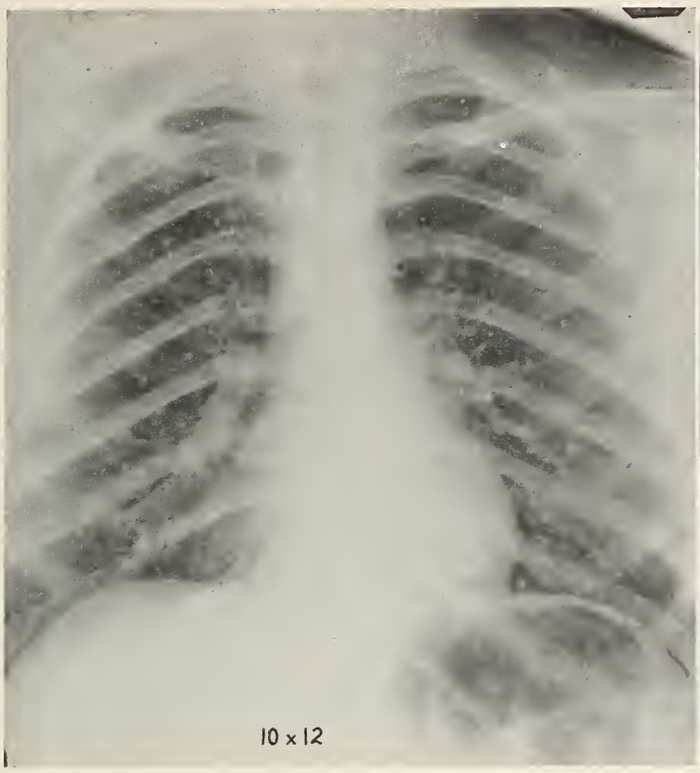


Fig. 4. Chest x-ray of Betty Jean S. in September, 1944, showed multiple fine discrete areas of increased density in both lung fields.

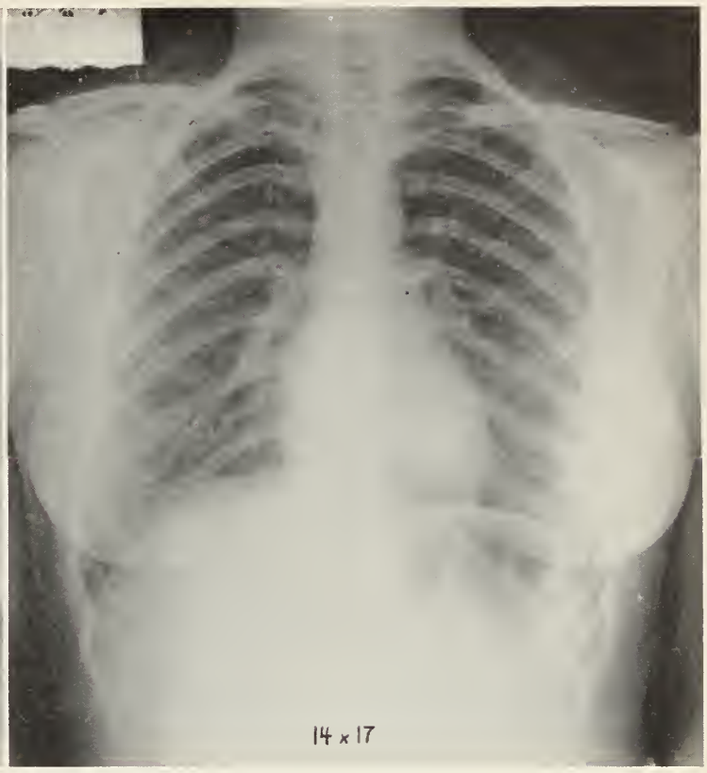


Fig. 5. X-ray of Betty Jean S. in January, 1947, showed an unchanged pattern of pulmonary calcifications.

Helen S., aged sixteen, had no complaints in October, 1944. Her lung fields, hilar areas, heart, and diaphragm were all considered normal in a chest x-ray. Clinically she appeared in good health.

She had had pyelitis in 1943, and again in 1939, at the same time as her sister, and a tonsillectomy in 1940 which was followed by postoperative hemorrhages for about two weeks.

On November 6, 1946, she stated that she had been in the Cumberland Valley for two weeks in August, 1946, and also during the entire summer in 1945. The histoplasmin test revealed some tenderness and itching and a raised area of erythema about 2 by 4 cm. in size.

Chest x-ray studies on December 5, 1946, revealed no changes in the lung fields nor hilar areas.

Anna S., aged fifteen, was in Tennessee all summer during 1945, and also in 1946. At that time she had a cough for more than four weeks but had no hemoptysis. Her histoplasmin test showed a strongly positive reaction 1 by 2.5 cm. in size, and was indurated and painful.

An x-ray of her chest (Fig. 3) on November 5, 1946, showed the heart, trachea, and left lung to be clear. In the mid-portion of the right chest in Zone 2, there was a dense irregular mass of calcareous tissue; and multiple masses of partly calcified material were seen in the lower hilum. The parenchyma was not involved. Just lateral to the right cardiac border some small spherical lesions with lighter central cores had the appearance of tiny buttons, crescents, or doughnuts.

Another x-ray study of her chest on January 20, 1947, revealed very little change. Some sharpening of the outlines of the lesions in the right mid-chest was observed, and some lesions appeared slightly smaller.

Betty Jean S., aged thirteen, stated that she had lived in Tennessee (Salinas) during July and August of 1940. Many of her playmates had a periodic cough all that summer. During that time she had a fever of 100° to 101°, her eyes were red, her nose ran, and she had a loose constant cough, but never hemoptysis. Both sisters and her mother were with her at that time.

She had had pyelocystitis in 1938 and in 1939. She had never had hay fever, to her knowledge.

In September, 1944, she felt ill for about a week. This was followed by a cough lasting for over three weeks. On September 23, 1944, a chest roentgenogram (Fig. 4) revealed multiple fine discrete areas of increased density scattered throughout both lung fields. Clinical examination of the chest was negative.

On November 6, 1946, her height was 5 feet 1 inch, weight 106 pounds. The histoplasmin test revealed tenderness, and an indurated area 2.5 cm. in diameter, and was considered strongly positive. An x-ray of the chest on November 2, 1946, showed the miliary lesions throughout both lungs to be generally more sharply outlined and more dense. Some of the individual areas were smaller in size, but none had disappeared, as was shown by superimposing the more recent film over the original x-ray. Her blood count on that day revealed the following: hemoglobin, 78 per cent, 11 gm.; red blood cells, 3,580,000; white blood cells, 7,800; neutrophiles, 54 per cent; small lymphocytes, 37 per cent; eosinophiles, 4 per cent; and some anisocytosis of the erythrocytes.

On February 1, 1947, her blood smear was examined by Dr. E. L. Heller of Pittsburgh, who stated that her hemoglobin was 85 per cent, red blood cells 4,210,000, and white blood cells, 7,200. The smear showed an

average of 3 eosinophiles per high power field. He stated, "There is no characteristic blood picture in this disease."[8]

At this time, an x-ray of the chest (Fig. 5) revealed the same pattern of pulmonary calcifications as that observed in November, 1946.

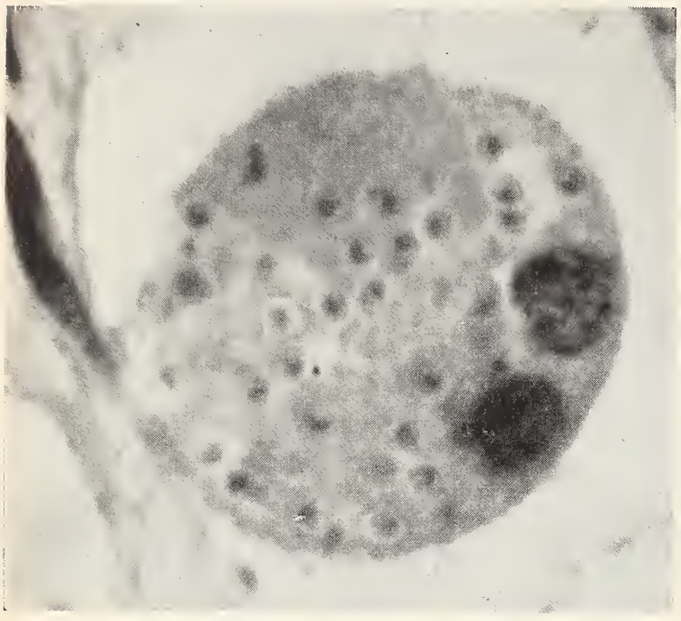


Fig. 6. Histoplasma (yeast-like phase) within a phagocyte from a lymph node. H. and E. stain, magnification ×1800. Courtesy of Dr. S. E. Gould.

NOTE: The histoplasmin for the tests was kindly furnished by Dr. Amos Christie who also reviewed the series of chest roentgenograms. One-tenth of one c.c. of a dilution of 1 to 100 was injected intracutaneously and was read after seventy-two hours in all of the cases. The decreased sensitivity of both parents to the histoplasmin agrees with Christie's findings that people past the age of twenty years seem to lose their sensitivity.[2] Von Pirquet and Mantoux tuberculin tests on the entire family in October and November of 1946 were negative.

Discussion

This family has been in the habit of vacationing during the summer months in Tennessee. During the summer of 1944, the children vacationed in the city of Salinas where two of them became ill, with malaise and a persistent cough. One child showed a protracted low grade fever, weight loss, a leukopenia and an hypochromic anemia of mild degree.

Serial x-ray studies of their chests showed multiple discrete crescent-shaped or button-shaped areas scattered throughout the lung fields and hilar areas. The appearance of many of the lesions was caused by an outer spherical zone of increased density surrounding a central less dense core.

Comparison of the appearance of these lesions shows a curious similarity to the appearance of the individual histoplasma organism as shown in the photomicrograph in Figure 6.[12a]

Summary

A review of the recent literature on histoplasmosis has been presented. Recent studies emphasizing the evidence for a benign pulmonary form, apparently widespread throughout some sections of the United States, are contrasted with the grave prognosis usually described in the earlier literature.

In the case reports presented, the parents of three children were born in Salinas, Tennessee, and all members of the family have lived intermittently in that region. Four of the group are considered cases of benign pulmonary histoplasmosis. Although the entire family has been observed for nearly three years, and all members are clinically well at the time of this report, serial roentgenograms of two of the children, showing widespread pulmonary calcifications, demonstrate increasing density of the individual areas involved during the period of study.

The reactions to histoplasmin in this family and the reproduction of the Histoplasma capsulatum are not to be construed as proof of the etiology of the calcifications in the chest roentgenograms, since histoplasmin tests are not specific for this organism alone.

However, clinically the cases appear to fit descriptions of the benign form of this disease.

Conclusions

Since no effective therapy exists for this disease, it is suggested that persons with so-called benign cases, of the pulmonary form, at least, who move away from the areas in which they contracted the infection, should avoid returning to the same regions for any protracted stay, especially during the summer months, since apparently reinfection may occur.

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Aims and Purposes of the Specialty Boards

Special Reference to the American Board of Surgery

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IT MUST BE admitted that graduate medical education is only now beginning to emerge from the same chaotic state that undergraduate medical education found itself in thirty years ago. The great advances in medicine have made it necessary to admit that no one can possibly be adequately trained to practice safely in more than one of its main divisions. In recognizing this need, however, it must be remembered that today, as in the past, the greatest need is for the large majority of those who graduate in medicine to practice internal medicine or the general practice of medicine, whichever one chooses to call it. For those who wish to practice in a special field of medicine, an organized plan of training must be followed and the results of that training shown to be adequate.

This, in a broad sense, is the whole idea underlying the creation of the specialty examining boards. It is not the purpose of these boards to encourage more than are needed to enter into such specialty fields. Rather the definite purpose should be, and I believe is, to keep down the numbers of those wishing to enter a specialty field to those best fitted to do so. It is realized that in a democracy there should be as much latitude as possible in methods of arriving at a goal, but it should also be realized that a doctor's first obligation is to practice safe medicine and that this obligation is a higher one than his inherent right to go his own way in arriving at his goal. If this is admitted, it must mean that those who have successfully practiced either internal medicine or a specialty must formulate plans for the training of those to follow in their footsteps.

The specialty boards, graduate courses in medical universities, refresher courses in the various specialties, scientific societies, all have this common purpose. Medicine has passed the point where the only requirements for one to practice internal medicine or any of its specialty fields are graduation from a medical school and the individual's own announcement that he is a specialist. I know of no learned profession which has tried so hard to clean its own house and to meet the ever-changing public needs. It is certainly much more desirable that as members of the medical profession we assume this responsibility, rather than to wait for the government to step in and force it by law.

In discussing the subject of "Specialty Boards, Their Aims and Purposes," I wish it understood that I am not officially authorized to plead this cause. As medical secretary of the National Board since its organization in 1915, as chairman of the Organization Committee of the Advisory Board to the Medical Specialties, and as secretary of the American Board of Surgery for the past eleven years, I have spent a good part of my professional life helping in the attempt to set up reasonable standards for undergraduate and graduate training.

In order that we may better understand the specialty board problems it will be well to begin with the Advisory Board to all of the Medical Specialties, the reasons underlying its organization, its aims and purposes. This Advisory Board was organized in 1933-1934 to co-ordinate graduate education and certification of medical specialties in United States and Canada.

Several specialty boards had been functioning actively and successfully for a number of years prior to the organization of the Advisory Board for Medical Specialties. Their purposes were, primarily, to establish minimum standards of graduate educational and training requirements for physicians representing themselves to the public as being specialists, with certification of candidates by the boards after they had been able to pass the boards' examinations successfully. Secondarily, these boards hoped to improve the general standards of graduate medical education and facilities for special training. This aim is being steadily and rapidly accomplished.

The American Board of Ophthalmology was the first special certifying board to be created, in 1916. The American Board of Otolaryngology, established in 1924, was followed by the American Board of Obstetrics and Gynecology in 1930 and the American Board of Dermatology and Syphilology in 1932.

During part of this period of time, plans for the organization of similar boards in other specialties were being actively projected, all of these

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groups being desirous of availing themselves of the experiences of the already existing boards.

It was soon recognized that some formal and official plan of organization must be established. It was clearly essential that an examining board must have the official sanction of the national societies in its given specialty, as well as that of its related section of the American Medical Association, but there was, at that time, nothing to prevent unofficial groups from organizing examining boards and using the title, "American Board."

Consequently, in order to avoid duplication of effort, as well as to co-ordinate the work of the several boards and other interested groups into a concise and homogeneous plan for betterment, it was deemed advisable to create an Advisory Board which should give consideration to those problems common to all, and which should be representative of each organization concerned.

During the years 1933 and 1934, this Advisory Board was organized and began actively to function. Simultaneously at the Milwaukee session of the American Medical Association in 1933, a resolution was adopted authorizing the Council on Medical Education and Hospital: (1) to formulate standards of administration based in general upon those of the American Boards of Ophthalmology, of Otolaryngology, of Obstetrics and Gynecology, and of Dermatology and Syphilology, and (2) to recognize officially new boards meeting these standards, this recognition to be based upon previous approval and recommendation to the Council by the Advisory Board.

A constitution and by-laws for the Advisory Board was adopted at a meeting in Chicago on February 11, 1934. The original member organizations of the Advisory Board for Medical Specialties were: the Association of American Medical Colleges; the American Hospital Association; the Federation of State Medical Boards of the U.S.A.; the National Board of Medical Examiners; the American Board of Ophthalmology, founded 1916; the American Board of Otolaryngology, founded 1924; the American Board of Obstetrics and Gynecology, founded 1930; and the American Board of Dermatology and Syphilology, founded 1932. Two representatives were appointed from each of these organizations to serve on the Advisory Board. Since that time, the American Board of Pediatrics (1934), of Psychiatry and Neurology (1934), of Radiology (1934), of Orthopaedic Surgery (1935), of Urology (1935), of Internal Medicine (1936), of Pathology (1936), of Surgery (1937), of Anesthesiology (1938), of Plastic Surgery (1938), and of Neurological Surgery (1940) have been properly organized, approved and elected to membership in the Adivsory Board and recommended to the Council of Medical Education and Hospitals of the American Medical Association for official recognition. There are, therefore, fifteen examining boards now organized, approved, and actively functioning in the fifteen specialties recognized as suitable fields for the certification of specialists.

The work of this board has been aided by grants from the Josiah Macy, Jr., Foundation of New York, but the board is now supported by its component groups.

Article II of the constitution states: "This Board shall act in an advisory capacity to such organizations as may seek its advice concerning the co-ordination of the education and certification of medical specialists." Specifically, this represents an official effort to advance the standards and improve the methods of graduate education and training in the medical specialties, with certification of men thus educated and trained who qualify as specialists in the various branches. The common interest of the member organizations in these purposes is obvious. It is equally apparent that some fixed definition of specialties needed to be established, preferably on a graduate educational basis, that minimum standards of organization and conduct for new examining boards should be fixed, and that some official method of recognition be developed.

There is no desire on the part of these boards to interfere with any practitioners of medicine in any of their regular or legitimate activities. Their fundamental purpose is to ensure to the public, both lay and medical, and for their protection, that physicians claiming to be specialists, with presumably special proficiency in one or another branch of medicine, actually possess the qualifications they claim. This presupposes special training and demonstrable capability along certain lines of work. Suitable evidence of this is the ability of an individual to satisfy an examining board about his training and then to pass the examination for certification.

Surveys of existing facilities for graduate training in the various specialties are being conducted at the present time; residences as well as preceptorship and assistantship training are being studied; preparations for stimulating medical school and hospital

facilities for the required graduate training are going forward actively; round-table conference furnish discussions of subjects of interest in regard to graduate medical education.

The Council on Medical Education and Hospitals of the American Medical Association has agreed, under the authority vested in it by the resolution passed at the Milwaukee meeting (1933) and referred to above, that applications of special examining boards for official approval are to be referred to the Council through the Advisory Board for Medical Specialties, recommendation by the Advisory Board for such approval to be based upon the standards mutually adopted. The understanding exists that the Council cannot be bound by recommendations of the Advisory Board, but will consult the Advisory Board for Medical Specialties before acting upon any application so long as mutually adopted standards are in force.

Early in 1940 there was published the first edition of the *Directory of Medical Specialists,* containing the names and biographic data of all men certified by the several specialty boards, as well as information regarding the organization and functions of these boards. The third edition (1946) carries the names and medical biographies of 23,107 diplomates of the fifteen specialty boards.

In response to the generally recognized need for a clear formulation of the educational problems and principles involved in graduate and postgraduate medical training, the Advisory Board at its meeting in June, 1937, voted to create a Commission on Graduate Medical Educational to study the various aspects of the whole problem. This Commission included representatives of the profession, the specialties, the universities, the hospitals, the licensing bodies. The report of this Commission, comprising 304 pages, appeared in 1940, published by the University of Chicago Press, and is of real assistance to the various specialty boards, hospitals, medical schools, and regulatory bodies dealing with this phase of American medicine.

The Advisory Board is composed of two representatives from each of the approved examining boards in the medical specialties and such other national organizations as are interested in education, examination, and certification of medical specialists, and are duly elected to this body.

The constitution provides that "To be eligible for representation in this Board, an examining board in a specialty must be composed of members elected from or appointed by societies recognized by this Board as a national society in that specialty, together with representation from the related section of the American Medical Association." Upon being accepted by the Advisory Board, the board in question is recommended to the Council on Medical Education and Hospitals of the American Medical Association as qualified for recognition. Membership in the Advisory Board provides for the inclusion of the name of the organization in all lists and directories published by the Advisory Board for Medical Specialties and provides also for publication of the names of specialists certified by each individual examining board.

This Advisory Board reports directly to its member groups, and functions in close co-operation with the Council on Medical Education and Hospitals of the American Medical Association, and with the Advisory Council on Medical Education.

Meetings of the Advisory Board for Medical Specialties are held annually as required.

The American Board of Surgery, for which alone I may speak officially, was organized January 9, 1937. A plan of this organization had been carefully studied by a general committee representative of certain general and sectional surgical societies called together through the initiative of the American Surgical Association. As a result of the deliberations of this general committee, a tentative plan of organization was adopted. This plan was reported to the co-operating surgical societies and was approved, with the understanding that the board, when organized, would have the power to change or modify the proposed plan as it saw fit. This board has been created in accordance with the action of the Advisory Board for Medical Specialties as approved by the Council on Medical Education of the AMA, which has named certain specialty fields as being suitable to be represented by such boards. These boards have the two-fold purpose of certifying those found to be qualified after meeting reasonable requirements, and of improving existing opportunities for the training of specialists within the field concerned. This is to be done for the protection of the public and the good of the specialty.

The co-operating surgical societies selected joint-

ly to form the Board appointed their representatives as follows:*

The American Surgical Association	3
The Surgical Section of the AMA	3
The American College of Surgeons	3
The Southern Surgical Association	1
The Western Surgical Association	1
The Pacific Coast Surgical Association	1
The New England Surgical Society	1
	13

The term of membership is for six years. Each co-operating association has the appointing power of its representatives subject to the approval of the board.

Purposes.—(a) To conduct examinations of satisfactory candidates who seek certification by the board. (b) To issue certificates of qualifications to all those meeting the board's requirements. (c) To improve the opportunities for the training of the surgeon. (d) To set up principles of surgical education to apply to young men contemplating a career in surgery.

During the ten years the board has functioned, thirty different surgeons have served full or partial terms of membership.

The board has discharged its responsibilities by conducting examinations and has issued certificates of qualifications to those surgeons who have met certain, clearly specified, educational requirements and have successfully passed its examinations.

In discharging its responsibilities, the primary purpose of the board has been to establish and maintain a high standard in the education and training of the young surgeon.

The American Board of Surgery is not concerned with measures that might gain special privileges or recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the board to define requirements for membership on the staffs of hospitals. The prime object of the board is to pass judgment on the education and training of broadly competent and responsible surgeons—not who shall or shall not perform surgical operations. The board specifically disclaims interest in or recognition of differential emoluments that may be based on certification.

*The first three of these associations, being national in scope, were allotted three representatives each, the remaining associations one.

The requirements for all candidates will be as follows:

General Qualifications.—1. Moral and ethical standing in the profession satisfactory to the board.

The board, believing that the practice of "fee splitting" is pernicious, leading as it does to a traffic in human life, will reserve the right to inquire particularly into any candidate's practice in regard to this question.

2. Those whose activities are limited 100 per cent to the practice of surgery. This includes diagnosis, preoperative and postoperative care. It does not include obstetrics without surgical complications, or the general practice of medicine.

Professional Standing.—1. Graduation from a medical school of the United States or Canada recognized by the Council on Medical Education and Hospitals of the AMA, or graduation from a foreign school considered acceptable by the board.

2. Completion of an internship of not less than one year in a hospital approved by the same Council, or its equivalent in the opinion of the board. This internship may be rotating or one devoted to a single branch of medicine, as, for example, surgery, medicine, pathology, et cetera.

Special Training.—Candidates who have the following requirements will be eligible for consideration by the board:

Group I.†—Four years of education in surgery in a graded residency in one or more institutions. The training programs of hospitals must be approved by an appropriate committee of the board, in addition to the approval of the hospital for graduate training by the Council on Medical Education and Hospitals of the AMA or the American College of Surgeons. One year of the four may be in a subspecialty of surgery, such as thoracic, plastic, cancer, orthopedics, proctology, or gynecological surgery. If the second year of a two-year internship is surgical, and in a hospital approved for graduate training, it will be acceptable on the above four years.

Group II**—In lieu of the requirements for Group I, the board will continue to accept, for

†A graded residency includes a period of training in which the trainee has increasing responsibility for the care and management of surgical patients. Adequate operative experience in which the candidate has assumed the whole responsibility will be required.

**An acceptable residency is one approved for graduate training in surgery by the American College of Surgeons or the Council of the AMA.

the present, three years of acceptable residency training, followed by two years of study or practice of surgery. The latter two years may be taken under one certified by the board and acceptable for this purpose to the board and carrying on his practice in hospitals fully approved as meeting the minimum hospital requirements of the American College of Surgeons.

Each candidate must have three years of acceptable training in general surgery. It is desirable that the three years of acceptable residency training of Group II applicants precede the two years allowed in the study or practice of surgery, although this is not essential. Not more than two of the five years required of Group II applicants may be spent in the sub-specialties of surgery, such as those listed above.

Basic Sciences.—This entire period of special training shall be of such character that the relation of the basic sciences of anatomy, physiology, pathology, bacteriology and biochemistry is emphasized. The board does not insist that any special length of time be spent in the basic sciences, but knowledge of these sciences as applied to clinical surgery will be required in the examination. One year's credit, however, will be given to recognized graduate school courses in these basic sciences which are an integral part of an acceptable university medical school. The board does not recognize short postgraduate courses for credit on the five years required of Group II candidates.

As a rule, not more than six months' credit is allowed for one year or more spent in any one of the basic sciences unless the candidate can show evidence of special training during this period, such as research, teaching, et cetera, directly under the supervision of, and an integral part of, an acceptable institutional training program in surgery. Under no circumstances, however, will more than one year's credit be given for work in the basic sciences.

The American Board of Surgery gave a great deal of latitude to a candidate seeking its qualification in the first ten years of its work. Being convinced, after this experience, that of those examined, the candidates who had formal residency training in addition to the actual practice of surgery were the better prepared, its requirements

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The Nursing Problem

By T. P. Murdock, M.D.
Meriden, Connecticut

THE NURSING PROBLEM, particularly that phase having to do with the shortage of nurses, is probably the most serious matter confronting American medicine today. Hospital authorities have been complaining of their inability to staff their institutions adequately. Doctors have maintained that seriously ill patients were being denied badly needed nursing care. Nurses are insistant that they have been carrying an enormous burden due to the shortage.

That the seriousness of the situation is appreciated one can readily see by the actions taken by several national medical organizations, including the American Surgical Society, the American College of Surgeons, the American College of Physicians and the American Medical Association. All of these organizations have appointed committees to study the problem.

A nursing structure study is being conducted by Dr. Esther L. Brown for the National Nursing Council on a grant from the Carnegie Foundation. Because of her background and training and experience, it is expected that her study will be comprehensive and her report is awaited with great interest.

All interested agree that there has been and is a shortage. There is some disagreement as to the degree and cause of the shortage and methods of correction. A recent survey by the American Hospital Association seems to indicate some relief. Replying to a questionnaire, 2,300 hospitals answered, and of this number 37 per cent replied that if more nurses were available they would not need to engage them. We hope that when our study is completed all of these questions will be fully and finally answered.

"Facts About Nursing, 1947" shows some very unusual and interesting figures. In 1940 there were 371,066 graduates and students in training. In 1910 there were 82,327. Of the number in 1940, 97.7 per cent were women and 2.3 per cent were men. And of this number, there were 7,066 female negro nurses and 127 were males.

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Dr. Murdock is chairman of the Committee on Nursing Problems of the American Medical Association.

"Facts About Nursing, 1946" also provides some very interesting and unusual figures. The number in active practice 317,800. The number admitted to training schools in 1940—38,000. In 1942—47,500. In 1943—53,074. In 1944—67,051. In 1945—57,000. In 1946—30,899. From these figures, one notices the large increase in numbers admitted to training schools from 1942 and including 1945. This, of course, is explained by the Cadet Nurse Corps program. Were the increases due to patriotism? Glamour of the uniform? The stipend? The answer to the whole problem is probably in these figures.

The demand for nurses increases by leaps and bounds. In 1910 there was one nurse per 1,116 people. In 1946 there was one nurse per 316 people. One million more patients were admitted to hospitals in the U. S. in 1946 than were admitted in 1945. Prepayment hospital and medical plans have and will have much to do with this problem. As the plans increase in number and subscribers, the demands for hospital staff nurses and private duty nurses will increase and will have to be provided.

A report recently released by the Women's Bureau of the U. S. Department of Labor is staggering. The release estimates that the number of nurses needed in 1960 will be 500,000 to 550,000. This is based on an estimated population in 1960 of 153,375,000. It is described as "a realistic appraisal of possible attainment rather than an estimate of what ideally is desirable." To obtain what they describe as "ideally desirable" would require twice this number. As the result of the cadet corps training, 44,700 nurses were graduated in 1947. This was the largest class graduated. This standard will have to be maintained during the period 1951-1960 if the estimated needed result is attained. These figures may be fantastic. I hope they are.

The economic studies present some interesting conditions. It is difficult to work out an average salary paid nurses in the United States. In 1946 it was estimated that the average income of the nurse was $170 to $175 a month. In 1947 one estimate placed it at $185 a month. Another between $175 and $180. In general, the average week is forty-four hours. Social security is not provided. Only a few hospitals have provided retirement plans. The American Hospital Association has worked out a retirement plan. Only a small percentage of nurses have taken advantage of this, and only a few hospitals carry it.

One could ask why the shortage of nurses? There would be many answers, and included in these would be (1) the general woman power shortage due to the competition of business in the labor market, (2) relatively small pay and long hours of work, (3) poor living conditions and lack of provision for recreation in training schools, (4) lack of retirement funds, (5) not being covered by social security, and (6) what the nurses describe as a hard medical and nursing hierarchy.

I think we can all accept the first and second premises with the woman power shortage and small pay. These young ladies actually take graduate work that in time, at least, is comparable to college training, and are then required to work for a salary that could easily be obtained in other lines of work and without the added three years of training.

In many hospitals the living conditions of nurses are poor. Dormitories are crowded. Little or no provision is made for recreation. This is due to lack of funds or short sightedness on the part of boards of directors.

Retirement funds and social security must be provided. This is not said from a moral viewpoint. On the contrary, these must be provided if hospitals and other health agencies are to compete with industry and business in general.

The files of the committee contain a great many letters from nurses severely condemning what, in general, they call the hard medical and nursing hierarchy. The nurses, in these letters, state that doctors have been unfair and unjust in their criticisms. Using their own phraseology, they say that doctors have "lorded it over them." They are also critical of hospital administrators and nursing educators because of their dictatorial attitudes. This should be and probably can be corrected.

What is to be done about all this? It is a big and difficult problem. It concerns us all personally, and more than that it concerns American medicine greatly. There are those who would use this situation as an indication of the need of compulsory medical and nursing care. This is not so, and I deny it vehemently. It insults ones intelligence to be told that governmental interference, and I use the phrase advisedly, would provide more or better nurses any more than it would provide more or better doctors.

I would like to say, at this time, that the nurses are as anxious as any group to have this problem solved. They have been most co-operative and helpful to the committee.

The committee will make its final report to the House of Delegates of the AMA at the annual meeting in June. The study is nearing completion. It would be improper for me at this time to present it here even as far as we have gone. The report belongs properly to the House of Delegates. When it is in, I hope it will please everyone.

I can say that a permanent conference committee has been formed. This committee is made up of representatives of the nursing profession, the American Hospital Association and the American Medical Association. The Board of Trustees has appointed a committee to represent the American Medical Association. This conference committee has already begun to function and will attempt to solve problems common to all. The committee continues its studies along the lines of (1) immediate relief, (2) future planning for training of bedside nurses and nursing educators, and (3) economic studies.

The American Medical Association intends that this problem will be solved, and more, that never again will America find itself in this position.

The president, Dr. E. L. Bortz, has stated that all of the resources of the American Medical Association are behind this study. The Board of Trustees and the chairman, Dr. Elmer Henderson, have given the committee complete support. The editor of *The Journal,* Dr. Morris Fishbein, has greatly aided the committee from his large fund of knowledge of this subject.

The committee asks the help of all the doctors in the United States. It asks the endorsement of the National Conference on Medical Care. It is receiving great aid from editors of a great many state and county medical journals. Many of the editors have written several editorials.

This problem is one for nurses, doctors and hospitals executives to solve. It is not the problem of any one group. The nurses are allies and aides to doctors. It must and will be solved with the generous co-operation of all. The committee of the American Medical Association seeks the aid of all physicians.

Professional Building

Nursing—Service Aspects

By Janet M. Geister, R.N.
Chicago, Illinois

IT TAKES COURAGE to try to find answers to the major nursing problems that beset us today. Never has there been so much adverse comment on nurses and nursing. Complaints of shortages in quality and quantity come from all sources.

In the present so-called "crisis" there are no new major elements. We simply have here the cumulative results of conditions that have been developing for twenty-five years. They have been aggravated and sped to a climax by the pressures of war, the postwar health hunger, and the move in our society toward higher rewards for workers.

There is nothing wrong that cannot be remedied, if enough have the will to apply the remedies. Nursing is *of* the public and *for* the public. The doctor, hospital administrator, health authority, the patient and general public have a direct interest in it; therefore, the help of all is needed in attacking the problem of nursing.

The help that is primarily needed is not money or tears—though money is a part of the answer. Essentially we need new ideas. The old ideas of nursing education and the use of nurses are at the root of our present troubles. It is footless to chide the profession; nurses as well as our inadequately nursed patients are victims of outworn ideas. "We're out of step with the times," says the *American Journal of Nursing.*

The immediate causes of shortages of hospital nurses are the increase in beds and unsatisfactory personnel practices. The immediate cause of half-empty nursing schools is the rejection of nursing as a career with suitable rewards. The basic causes, however, lie deeper.

We cannot separate quantity and quality shortages from their relationship to nursing education. The two areas are inextricably forged together. Nursing education has a dual function—that of providing nursing to hospital patients and that of

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Chairman of the Advisory Board of the American Association of Industrial Nurses; formerly an executive of the American Nurses Association.

educating for nursing. Hospitals instituted this dual system in the 1870's as a public service. As its economic advantages became apparent, however, the motive changed.

Though the system was satisfactory in earlier days, by 1922 we were being warned by the Rockefeller Committee on Nursing that it was unsound and would lead to serious trouble. Ten years later the Committee on the Grading of Nursing Schools repeated the warning. Yet today 90 per cent of our 1,242 schools of nursing remain subject to hospital economics.

The advances of medical science and the great patient surge to the hospitals have placed heavy new burdens on the student nurse. More patients to do more things for—more things to learn! Doctors add one new procedure after another in their diagnostic and treatment methods, and each doctor must have things done his own way. New medical procedures must be followed by new nursing techniques, and the nurse must know enough to carry out orders intelligently. We cannot entrust human life to an automaton. The 1948 nursing curriculum can no more be a 1925 model than can that of any other living group.

It is idle to cry that we have "over-educated nurses." There are no such things. There are some *wrongly* educated nurses—and small wonder! The struggle between ward and class room has become exceedingly grim. The student with one eye on the clock for classtime and the other on the order book has little chance to learn the hundred little knowledges that make up the art of nursing. Our 1,200 schools have an average student body of eighty-five; there simply aren't enough able faculties to go around.

The results of the dual load on students are evident. Of the 1946 class, 32 per cent withdrew before graduation, and not all for matrimony. That high record of failure retards enrollment. Seasoned nursing administrators tell me that much of the complaint for inadequate nursing centers on graduates of recent years. The assembly-line form of nursing education forced on us by the war was good for neither nurse nor patient.

Both the Rockefeller and Grading Committees warned against the pernicious and wide practice of employing graduate staff nurses merely to supplement the services of students. It places the student in competition with the graduate, a first source of the deep resentments that later factored in the revolt from hospital work. This practice has delayed far too long the development of graduate staff nursing as a dignified, permanent, and substantial form of nursing. To it can be attributed some of the shortages that followed both World Wars. Hospital staff nursing still remains too much of a No-Man's Land—a blind alley.

The immediate causes of hospital nurse shortages are the greatly increased demand for nursing and the flight of nurses to other fields. Hospital bed occupancy increased 100 per cent in fifteen years —the nurse population but 13 per cent. Other fields are competing vigorously for quality nurses: industry, public health, the Veterans Bureau, Army and Navy Nurse Corps, doctor's offices, clinics.

Nurses were already turning away from hospital practice when the war sharply accelerated the movement. With many other jobs available, old resentments came to the surface. Inadequate pay was a handy limb on which to drape their grievances, but twenty-five other specific dissatisfactions with hospital duty are listed in the U. S. Bureau of Labor Statistics study. While 46 per cent were unhappy over the pay rates, 55 per cent complained of the lack of retirement and employment security. These things represent a most urgent need.

By the time conditions began to improve, it was the old story of "too little—too late." The changes were not basic enough, and nurses who had found useful employment elsewhere preferred to remain elsewhere. Too often the nurses drifting into the hospitals are those who cannot find jobs elsewhere. Then, the many splendid nurses who have carried the nursing load through the war and the postwar years, must work doubly hard to offset the indifferent and sometimes wretched nursing.

The market is still a "seller's" one. The good nurse who feels needed digs in even harder. The poor nurse, feeling indispensable, uses the moment for her personal advantage. She does the least, expects the most, and cries to Heaven over the injustices.

Hospital nursing should be our most attractive field. There is no good reason why it cannot be. The public must face the fact that nursing will cost more than it has. Good nursing, like good anything else, has to be paid for. The halo, too long offered as part pay, is a poor substitute for the hard cash the landlord wants. Nurses are reasonable in their requests. They want only to live as decently as other workers do, and they

do not want the alumni to support them when their legs give out.

Money alone, however, won't bring back the large numbers of quality nurses needed. Most of the twenty-six complaints listed in the Bureau of Labor study, other than those related to pay and retirement, deal with administrative practices. There isn't one, in my opinion, that can't be treated by some massive doses of the Golden Rule and common sense.

We humans criticize the things we don't understand. Few nurses can know the troubles that bedevil the administration, and few administrators know the troubles that bedevil the nurses. Both sides have their grievances. Patients need care nights and Sundays as well as in the hours nurses like best. Nurses want conditions that permit good nursing. Quality nurses hate hit-and-run work. They want something done about promotions, educational opportunities, avenues for settling grievances. The blind alley can and should become a main highway.

Money alone, I repeat, won't settle these matters. Only better pay and bringing nurses into the partnership will. Nurses have always had to obey the rules; why not let them help make the rules? They can be trusted. Recovery can come only from the free interchange of opinions and ideas —and subsequent compromise—from a 1948 concept of the principles of human relations. It cannot be achieved along the old lines of military discipline. We can no longer expect good nurses to be thinking people in relation to patient care, and robots about everything else.

Another major need relates to supervision. The stress of recent years broke down much of our good supervision, yet supervision is the very backbone of good nursing. Without it, inevitably the patient suffers. The doctor goes away; the family goes away; the floor manager must take the place of both in protecting the patient's interests. She is a four-way transmitter between doctor, patient, management and staff. If she stays unwrinkled and untroubled at her desk, then Heaven help the patient!

A good supervisor can strengthen weak nurses; a poor one can confound the best efforts of good ones. Six good nurses under a good supervisor can make circles around twelve mediocre ones under a weak supervisor. The best dollar investments of the hospital, in my opinion, are those put into quality supervision.

We cannot plan on huge numbers of nurses in the future. The U. S. Bureau of Education believes there will be fewer girls available who are suited for nursing. We must learn to use the nurses we have, and those we get, with greater economy. The new costs of nursing are an added reason for this.

Scarcities, plus the great increase in the chronic population, have brought the practical nurse into the scene. She is here to stay—the latest helper on the doctor's expanding team. Many nurses, however, do not understand the *why* of her coming, and resentment remains high. It is not surprising. Nursing leaders took little trouble to help nurses understand the reasons for her presence. Abruptly she was thrust upon us, and a profession long-trained to protect nursing standards was told to support schools and legislation promoting her use. Inequalities in pay and privileges have angered the professional nurses. These must be leveled off before there can be peace.

Some poorly prepared practical nurses have assumed prerogatives and authorities that have shocked the graduates. This is not true, of course, of the well-trained practical nurse, but she is still scarce. The lines of demarcation between the two realms are still not clear. One reason is that, through custom and tradition, many tasks that are hospital service and not strictly nursing have been a part of the graduate's job. Time, test and patience are needed to get the lines straightened.

No situation in hospital practice today calls more for intelligent handling. It is a mistake in any realm to go ahead of public opinion. The co-operation of staff and private duty nurses is essential to the successful use of the practical nurse. It can be gained only through understanding and a share in policy-making—not through orders. I have an infinite faith, that the average nurse, once fully informed, can be trusted to co-operate for the good of the whole.

A more economical and efficient use of nursing calls for the co-operation of everyone concerned. The doctor can help in many ways. When nurses inadvertently or carelessly confuse the practice of nursing with that of medicine, the doctor can help them understand where the line is. It moves as medical science advances. Some of yesterday's practice of medicine is today's practice of nursing. During the war some medical tasks were assigned to nurses. The line has since then been blurred. Good nurses don't want it that way. They want

to practice *nursing*. On the nursing school committee the doctor can help greatly in modifying or strengthening the curriculum, according to the demands made on nurses.

The administrator can save many *miles* of travel by readjusting traffic lanes and the physical setup. It is sheer waste for a nurse to walk half a block to sterilize a needle and even farther to get ice cubes. Hospital architects, charmed with their long vistas, ought to consider the help's feet more.

Hospital boards, whose contact with hospital realities is too often only the paneled directors' room and the auditor's statement, have a responsibility for being better informed. The board president who said the eight-hour day had dimmed the light of Florence Nightingale's lamp might

(Continued on Page 814)

CORRECTION

In the paper, "Surgical Treatment of Carcinoma of the Breast," by Dr. S. W. Harrington of Rochester, Minnesota, which appeared on pages 40 to 50 in the January, 1948, issue of THE JOURNAL (J. Michigan M. Soc., 47: 40-50, Jan., 1948), Figures 5 and 6 were incorrect. The corrected Figures 5 and 6 are presented here.

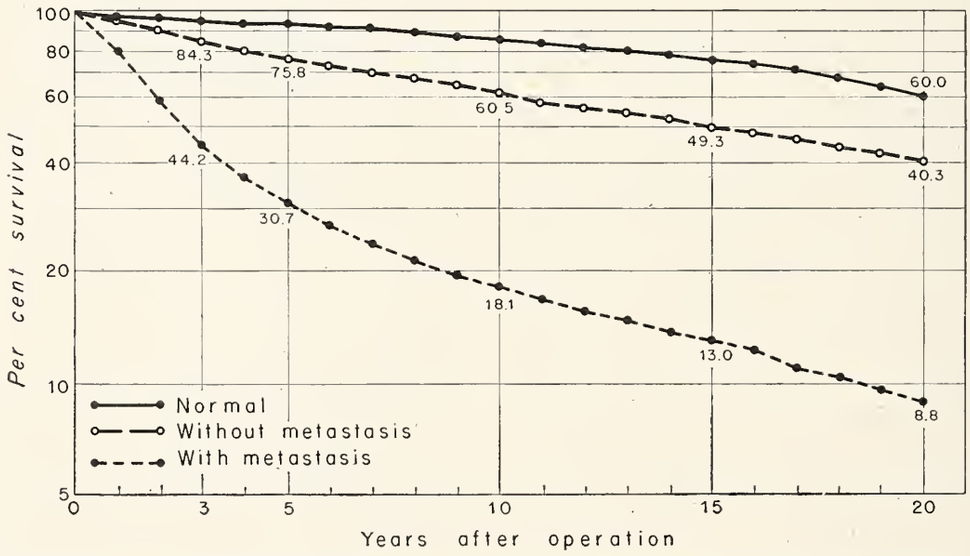


Fig. 5. Survival rates of patients who had undergone radical mastectomy for unilateral carcinoma of the breast with and without axillary nodal metastasis, as compared with normal life expectancy.

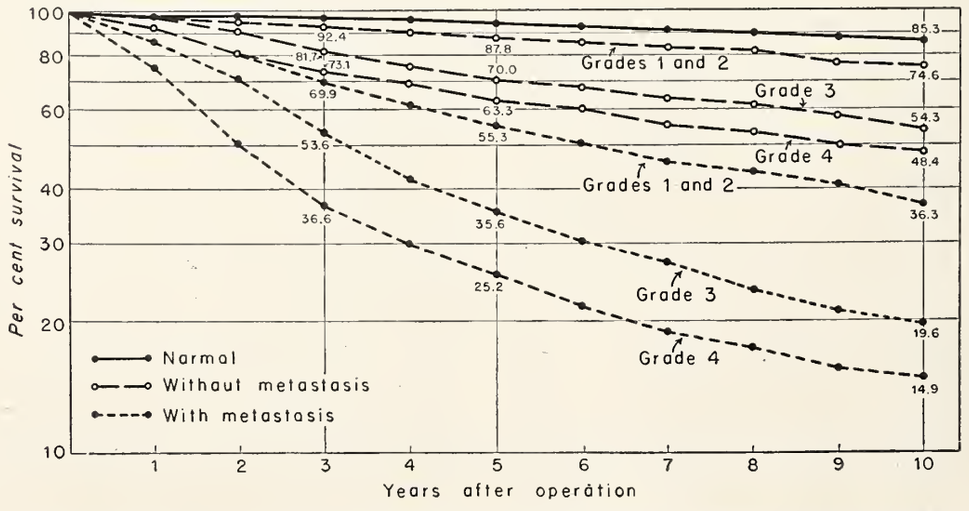


Fig. 6. Survival rates, by grade of malignancy of the lesion, of patients who had undergone radical mastectomy for unilateral carcinoma of the breast with and without axillary nodal metastasis, as compared with normal life expectancy.

Licensure to Practice

The objectives of the Basic Science Board and the Board of Registration in Medicine should be two:

First, to protect the public by preventing from practicing the healing art in Michigan those who are not qualified to practice.

Second, and more important, to assist in obtaining a license for those who are qualified and who wish to practice here. A proper corollary to this might well be to aid in every possible way those taking postgraduate work in an effort to better qualify themselves for licensure and practice.

So far as Doctors of Medicine are concerned, objective No. 1 is already a *fait accompli*. We doubt if any unqualified Doctors of Medicine are being licensed at this time.

The efforts to accomplish the second objective have been woefully bungled. With no thought of placing blame on any individual or group of individuals, suffice it to say that the present situation is bad. We need more Doctors of Medicine, especially in rural areas. We need to offer our splendid hospital training facilities to the graduates of our medical schools and medical schools from other states without the formality of license to practice during the training period. We need a reasonable reciprocity with other states for men licensed to practice in those states. We have none of these things now.

That Governor Kim Sigler and his special counsel, Mr. H. H. Warner, have taken an active interest in this problem, is wholesome. We deeply appreciate their efforts and sincerely hope they will follow through until all possible corrections have been made.

P. L. Ledwidge

President, Michigan State Medical Society

President's



Page

Editorial

UNTRUE TRUTHS

HITLER BUILT his whole career on repeating and repeating half truths or untruths. Stalin seems to be having much success by not telling the whole truth—by misleading people by misrepresentation. The whole Communistic movement is built upon taking a partial truth and building it up by repeated telling, so that the hearers believe it in the end. It is a well-known psychological principle that if told sufficiently often, and with conviction, any untruth may seem to be fact.

The socializers of medicine are working on that principle. Any minor unsatisfied health needs of the people have been so stressed that many people believe them to be major. F.S.A. Administrator Oscar R. Ewing is quoted in the *New York Times,* April 18, 1948, as saying, "While it is true that some sections in the United States have medical care equal to that anywhere in the world, it is also true that in many areas in the United States the medical facilities are among the worst in any civilized country."

We have repeatedly mentioned exaggerated claims in the program for socialization, and now have another sample which, on the face of it, appears to be pure propaganda. This time the propaganda effort has taken the form of a book for the information of the public. The old and tried idea of exaggeration is foremost.

"YOU AND YOUR DOCTOR"

SUCH IS THE title of a very cleverly written book just off the press. The author, Benjamin F. Miller, M.D., is clinical professor of medicine at George Washington Medical School and research associate in medicine of the National Research Council. He was formerly associated with the University of Chicago Clinics and the United States Public Health Service. We were told about this book by a layman; we sent for it, paid $2.75 for it, and noted the copyright reservation: "All rights reserved. This book, or parts thereof, may not be reproduced in any form without permission of the publishers." We immediately wrote the publisher asking permission to make quotations in a possible review for the *Journal of the Michigan State Medical Society.* We waited six weeks and received no reply, so shall make no quotations.

The book is a definite argument for government-controlled group practice of medicine. The author mentions the Wagner-Murray-Dingell bill several times as ideal; he says there are just two agencies which can co-ordinate complete medical service for the whole nation: the American Medical Association, of which he claims to be a member, and the United States Public Health Service, of which he has been a member and now holds a reserve commission. The former will not see anything but private practice, and the latter can do the job, in fact was designated in the Wagner-Murray-Dingell bill.

The author claims throughout the book that the present method of practicing medicine by private endeavor is wholly inadequate to give the public the supreme service to which every individual is entitled, and the costs are also too high. His facts have a modicum of truth, but are so exaggerated that a false impression is given of what a patient can reasonably expect, with the implication that too many things are neglected, the distribution of special skills are inadequate, and the absence of clinics so obvious that proper study of the case is impossible.

To point the necessity for such a change in the practice of medicine, Dr. Miller discusses many problems, among them the impossibility for the private practitioner to secure specialist advice and counsel in most of his cases because the patients cannot afford to pay. Broad statements are made that sound plausible to the reader, but does any well-informed doctor of medicine believe that today 40 per cent of our counties lack any supervision of health standards? He implies that an enormous mass of the population is helpless. Speaking of emotional illness, he says that in any city of less than 100,000 it would be difficult to find any physicians trained in psychotherapy. The statement is also made that one person in every fourteen needs psychiatric study, which, if adequately done, would take from eighteen months to three years and would cost $1,500 to $3,000 per year. He advocates that the government take over this task. A true picture? Or fantastic?

Dr. Goin and many others have analyzed the

selective service records, and have shown how they have been misquoted; but they have shocked this author out of any complacency because well over 4,000,000 young men were rejected for medical reasons.

Another reason for the need of Wagner-Murray-Dingell and group practice on a large scale, says Dr. Miller, is the tremendous rush the average doctor is under, and his utter impossibility to find time or facilities to give his patients the care they are actually entitled to. To prove this point, an average day of an average general practitioner in a city of 50,000 is outlined in great detail. This general practitioner must do his own surgery because there is no good surgeon in less than 200 miles. (Do you believe that?) This doctor's schedule is: a very elaborate 10 minute wash-up of the hands and arms, followed by immersion in disinfecting solution, because the surgeon must have sterile hands; then follow: two tonsillectomies, done first; a herniotomy; a gall-bladder resection, which would have been sent to a surgeon if one had been available; a thyroidectomy for a toxic goiter; a call to a house for an obstetric case, for which hospitalization has to be arranged; a house call for a heart patient for whom portable electrocardiogram is ordered; ten routine house calls; an office full of patients; before they are finished, a call to the hospital for the obstetric case, which proved to be version; then, office work in the evening.

We wonder if any of our general practitioners are that busy. It looks like a distorted picture, the same as the other matters described; the author's pet theme is that most of our general practitioners, to be prepared for their manifold tasks, really need seventeen years of hospital training. He proposes that they become instead "pilot physicians," to look after minor things and to refer the patients to the proper specialists for better care.

The only good feature we were able to see in the book is the price, which will assure that its readers will be few. We have been impressed by the temerity of this doctor, writing about the practice of medicine when he very evidently has been an educator or administrator. Where does he get his experience?

COMPULSORY HEALTH INSURANCE

BY THE TIME this number of THE JOURNAL is distributed, the national political conventions will be over, and we will all know the possible trends of social change, especially the changes in what we choose to call political medicine, or by its time-honored term, "socialized medicine." We have samples in most other countries, and we do not like them. Neither do the people, the patients. We hesitate to contemplate the future of medicine in Great Britain, but we must face facts.

It can happen here. President Harry S. Truman, in his "presidential tour" of the country, in his very first speech reiterated his demands for a national compulsory health service. We all know where he stands, and his whole administration—especially the entrenched bureaucrats, Falk, Altmeyer, Ewing, to mention only three.

Governor Thomas E. Dewey of New York has stated repeatedly that he is positively opposed to any kind of socialized medicine or compulsory government sickness insurance. He promises a complete house cleaning in Washington.

> "Compulsory socialized medicine is no good. No variation of it is any good. It has never worked. It cannot be done. . . . It would utterly destroy the quality of medical care. . . . If a thing is evil the first job is to convince the people that it is evil and is thoroughly evil, and destroys everything that we believe in. I am unalterably opposed to it."*

Senator Robert A. Taft of Ohio has taken a well-known stand in complete opposition to socialized medicine, and has fathered the only proposal that we as medical men can accept. His bill protects us from the fear of socialization. He has spoken in Michigan, and we have published his remarks.

Harold Stassen's position can best be understood by studying his own words:

> "I propose specifically that our Republican Party adopt as its program that it will inaugurate a system of medical and health insurance to cover major cases, and only the major cases. This could be done with reasonable administrative simplicity by basing it first of all upon the coverage of those on social security for medical and hospital expenses in excess of $250 in a single calendar year. By an effective administrative establishment requiring the verification of claims, *the reasonableness of charges,* and a *spot-check for improper bills,* the entire system could be efficiently and effectively administered on a *federal-state basis. . . . I see no manner of effectively providing this protection except through action by government.*" (Italics ours.)

Governor Earl Warren of California is for socialized medicine. He promised the doctors of

*Speech before the House of Delegates, Oregon State Medical Society, May 1, 1948.

California to oppose the measure, but himself stimulated legislation to bring it about. The doctors of his state were chagrined and irked, and only succeeded in defeating his program by one vote. Advocates of the governor are now going about the country telling workers that the medical society has Governor Warren all wrong, that he is not really in favor of socialized medicine. And many people are believing that the medical profession is misinformed.

Henry A. Wallace is all out for the extension of social welfare, including complete medical care for everyone.

Our own Arthur H. Vandenburg, has told us where he stands—unalterably opposed to socialized medicine. He complimented Michigan on an outstanding fight against socialized medicine, and dubbed our Blue Cross-Blue Shield a great public trust.

DRAFTING DOCTORS

DOCTORS, DENTISTS and possibly some other "scarce" occupational groups will face a special draft under military manpower legislation now being considered by Congress. House Bill 6401 provides for the common defense by increasing the strength of the armed forces. One section of the bill would authorize the President, pursuant to requisitions submitted by the armed forces, to require a special registration of and make special calls for members of the medical profession who have not reached the age of forty-five years at the time of such call. Physicians so called would be liable for induction, for a period not to exceed twenty-four months in the armed forces. By this section, physicians over the age limit applicable to inductees generally would be singled out as a group from their fellow citizens for special draft, induction, or selection.* Other citizens would be exempt if over twenty-six.

Never in history have doctors failed to respond for needed service in the military, and we have no reason to believe that times have changed. Older doctors will thus be provided, and the younger ones will be included in their own age groups of inductees, and doctors are now being graduated well under twenty-six. These would probably provide most of the physicians essential, except for the leavening of older heads. This latter would be met voluntarily.

The immediate needs of the Army and Navy Medical Departments could justly be met from the ranks of some 8,000 or 9,000 civilian doctors who are in their twenties, whose professional education was, in part at least, paid for by the government, and who have given no, or very little, service in return.

The Council on National Emergency Medical Service has urged the immediate establishment of a civilian medical board at the highest level of government, similar to the National Security Resources Board, to be responsible for the medical, health, and sanitary services of the civilian population, of industry, of agriculture, and of the armed forces in time of emergency or national mobilization. The establishment of such a board is absolutely essential to prevent a repetition of the thinning of the ranks of civilian physicians.

We suggested early in the last war that the names and numbers of physicians needed by the military be determined, indoctrination be given, the doctor returned to private practice until needed. His needed service could be anticipated in sufficient time for formal training and conditioning.

UNETHICAL DOCTORS

In a report on his program to weed out unethical doctors in the veterans' outpatient departments, Dr. Paul B. Magnuson said twenty-eight cases had come to light. Only a few criminal cases were found. These have been referred to local district attorneys.

The unethical doctors are being dealt with by state medical societies, which discipline offenders and remove them from the rolls of men eligible to practice veterans' medicine. The medical director said he was pleased that only twenty-eight violations have been discovered among 87,000 doctors.—*Editorial, Hospitals Journal, May, 1948.*

*Eliminated in final passage.

MSMS

BENIGN PULMONARY HISTOPLASMOSIS

(Continued from Page 740)

7. Hausmann, G. H., and Schenken, R. J.: A unique infection in man with a new yeast-like organism. Am. J. Path., 9:925, (Nov.) 1933.
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10. Morgan, D. K.: Histoplasmosis, et cetera. Bull. School Med., Univ. Maryland, 30:69-79, (Oct.) 1945.
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Committee Annual Reports

ANNUAL REPORT OF BEAUMONT MEMORIAL COMMITTEE—1947-48

As stated in our previous report, Professor Lorch, Professor Emeritus of the School of Architecture, University of Michigan, has been very interested in endeavoring to get the original plans of the Early House, which is situated at the site of the store of the American Fur Trading Company in which Alexis St. Martin was injured. A number of meetings have been held with Professor Lorch, who now has some very interesting material as a result of his long search.

The Committee is planning to have a meeting some time in June to consider these findings of Professor Lorch, and at that time we hope to meet with the members of the Mackinac Island State Park Commission so that plans for development of the Early House as a museum may be furthered.

Respectfully submitted,
F. A. Coller, M.D., *Chairman*
F. C. Kidner, M.D.
A. W. Lescohier, M.D.
H. C. Mayne, M.D.

ANNUAL REPORT OF COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE—1947-48

Your Committee on National Emergency Medical Service has engaged in the following activities during the year 1947-48.

At the request of the chairman of The Council, the chairman of this committee attended the meeting of the National Emergency Medical Service Council of the American Medical Association in Chicago on April 5 and 6, 1948. Following this meeting, his report was presented to the Executive Committee of The Council of the Michigan State Medical Society, by whom it was referred to this committee.

The committee met on May 18, 1948, and considered the above report and the recommendations contained therein, suggesting that The Council put these recommendations into effect.

There have been no other actvities during the year.

Respectfully submitted,
H. F. Becker, M.D., *Chairman*
W. H. Gordon, M.D.
R. F. Hague, M.D.
J. A. Ramsey, M.D.
S. W. Hartwell, M.D.
W. G. Ellet, M.D.
W. H. Alexander, M.D.

ANNUAL REPORT OF ETHICS COMMITTEE—1947-48

Your Ethics Committee begs to report that it has had nothing to do during the past year. No County Medical Society has referred any matters to this committee, an appellate body.

This denotes a very healthy condition of affairs and is evidence of harmony within the profession.

Respectfully submitted,
G. B. Hoops, M.D., *Chairman*
A. J. Baker, M.D.
L. W. Geib, M.D.
L. C. Harvie, M.D.
L. J. Morand, M.D.
R. S. Morrish, M.D.
W. E. Nesbitt, M.D.

ANNUAL REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY—1947-48

No formal meetings were held but the members were advised by communications as to various activities mentioned by the Executive Committee of the Michigan State Medical Society. Their opinions and any suggestions they had to offer were requested at that time.

However, the chairman with Dr. Amos did meet with the officers and members of the Woman's Auxiliary on two occasions, the first on December 10, 1947, at which he stated that he felt his committee was more of a liaison body than advisory.

The other occasion was at the home of the president of the Auxiliary to the Michigan State Medical Society, Mrs. T. Grover Amos. Also attending were President-Elect Mrs. Willis L. Dixon, Dr. LeRoy Hull, Dr. T. Grover Amos and Mr. Hugh Brenneman.

Out of that meeting arose the following suggestions:

1. That the president of the Auxiliary have some say in the election of the chairman of the Advisory Board and possibly one of its members—these doctors to be interested in Auxiliary activities.

2. That both the Advisory Committee and the officers of the Auxiliary be notified at the beginning of their term as to their relationship and duties.

Respectfully submitted,
T. P. Clifford, M.D., *Chairman*
T. G. Amos, M.D.
Alfred LaBine, M.D.
C. W. Oakes, M.D.
P. A. Riley, M.D.

ANNUAL REPORT OF COMMITTEE ON INDUSTRIAL HEALTH—1947-48

The Committee on Industrial Health held a meeting in Lansing on February 4, 1948, for the purpose of formulating plans for the year. It was felt to be too late in the year for developing plans for a spring meeting. It was proposed as an alternative that an offer of aid in planning and arranging a regular schedule meeting for County Medical Societies be extended to most counties of the state. The plan as finally developed was to offer to county societies a speaker or a panel of speakers for use as a regular medical meeting some time during the year.

The details of working out the plan, of contacting county societies and of securing speakers were left in the hands of the chairman and these plans are now being developed.

Respectfully submitted,
H. H. Gay, M.D., *Chairman*
A. L. Brooks, M.D.
W. P. Chester, M.D.
Henry Cook, M.D.
W. A. Dawson, M.D.
V. S. Laurin, M.D.
K. E. Markuson, M.D.
J. D. Miller, M.D.
N. W. Scholle, M.D.
C. D. Selby, M.D.
H. T. Sethney, M.D.
M. W. Shellman, M.D.
E. C. Sites, M.D.
F. B. Williamson, M.D.
J. L. Zemens, M.D.

ANNUAL REPORT OF STATE INTERPROFESSIONAL COMMITTEE—1947-48

Two meetings of the committee were held during the past year. The first meeting was in conjunction with the Detroit Interprofessional Council on November 18, 1947, and the second meeting was February 8, 1948, in the Porter Hotel, Lansing.

Following the two meetings of the committee, local Interprofessional Council movements have been inaugurated in Flint by Dr. S. T. Flynn; in Saginaw by Dr. L. C. Harvie; and in Lansing by Dr. K. P. Hodges.

The Interprofessional Council of Detroit has secured a State Charter. This was done to protect the name "Interprofessional Council." As the various groups throughout the state become organized they will be admitted to state membership. It is the hope of your committee that other groups will form so that a strong state organization will ultimately develop in the near future.

Respectfully submitted,
W. W. Babcock, M.D., *Chairman*
V. C. Abbott, M.D.
C. S. Clarke, M.D.
S. T. Flynn, M.D.
S. W. Hartwell, M.D.
L. C. Harvie, M.D.
K. P. Hodges, M.D.
R. G. Laird, M.D.
E. C. Miller, M.D.
G. W. Slagle, M.D.

ANNUAL REPORT OF COMMITTEE ON NURSES TRAINING SCHOOLS—1947-48

The Michigan State Medical Society's Committee on Nurses Training Schools held no meeting during the year of 1948. Inasmuch as a permanent committee has been formed comprised of a committee of doctors representing the Michigan State Medical Society, the Michigan State Nursing Association and the Michigan Hospital Association to cover more comprehensively the work of the training school in the hospitals, it seems superfluous to call a meeting of the committee when more can be accomplished through the permanent committee.

Respectfully submitted,
C. G. Clippert, M.D., *Chairman*
R. L. Haas, M.D.
H. D. McEachran, M.D.
E. A. Oakes, M.D.
W. J. Smith, M.D.
R. A. Springer, M.D.
D. W. Thorup, M.D.

ANNUAL REPORT OF COMMITTEE ON DISTRIBUTION OF MEDICAL CARE—1947-48

This committee did not hold a meeting during this period. A short time after the annual meeting in 1947, the chairman wrote a letter to the Executive Secretary asking him for advice on the necessity of holding a meeting, and to please let me know if there were any matters to be considered by this committee.

In the early part of 1948 a personal letter was written to each member of this committee asking him if he knew of any problems that should be considered by us. To date no matters have been referred for consideration.

Respectfully submitted,
C. W. Colwell, M.D., *Chairman*
R. H. Baker, M.D.
H. F. Dibble, M.D.
E. M. Vardon, M.D.
J. A. Witter, M.D.

ANNUAL REPORT OF CHILD WELFARE COMMITTEE—1947-48

The Child Welfare Committee had two formal meetings during the year, at which time many items of interest were under discussion.

Particular attention was given to the revision of the manual on "Immunological Procedures" which is to be published and distributed by the Michigan Department of Health, carrying the approval of the Michigan State Medical Society and the Academy of Pediatrics (Michigan branch).

One of these meetings was held at the State Laboratory, so that members of the committee had opportunity to observe the excellent facilities provided for the manufacture of biologicals.

For the coming year, it is recommended that the committee pay particular attention to the problem of prematurity.

Respectfully submitted,
R. M. Kempton, M.D., *Chairman*
Moses Cooperstock, M.D.
Carleton Dean, M.D.
A. M. Hill, M.D.
J. L. Law, M.D.
R. J. Mason, M.D.
A. L. Richardson, M.D.
R. S. Simpson, M.D.
L. P. Sonda, M.D.
Kenneth Wells, M.D.

ANNUAL REPORT OF COMMITTEE ON RHEUMATIC FEVER CONTROL—1947-48

The Committee on Rheumatic Fever Control has had five formal meetings and contemplates two more before the annual meeting in September. In addition, several meetings of subcommittees and individuals have been called on short notice to cope with the many urgent and special problems as they arose.

In addition to the multitudinous problems of policy and operation of the various centers the year's activities have seemed worth while. There are now thirty centers established in Michigan covering every county in the state. Through these centers have gone 3,000 patients, 414 of whom have been given a diagnosis of rheumatic fever.

The committee has accomplished many things and has established the foundation for much future activity and expansion.

1. Activated sixteen centers in Wayne County involving the participation of every major hospital in the area. Activated a new center in Alpena and another in Muskegon. Each had an appropriate program in which one or more members of the committee participated.
2. Established a file on Methodology as to the operation and conduct of each center.
3. Revised financial records and reports of all centers.
4. Written articles for The Journal and established interviews with the press local, state and national, publicizing our Michigan Program.
5. By invitation talked to thousands of people in Michigan on various subjects pertaining to Rheumatic Fever.
6. Edited and printed a brochure on diagnostic standards to be used particularly in Wayne County. Edited and printed a brochure for lay consumption explaining the Michigan Plan of attack on the Rheumatic Fever problem.
7. Furthered and encouraged the already existing very fine lay co-operation, particularly that exhibited by the Alpha Phi Sorority.
8. Restated to the physicians of Michigan the policy of the State Medical Society in the following letter:

"Dear Doctor .....:

"Your County Medical Society, in co-operation with the Michigan State Medical Society, has established a Committee on Rheumatic Fever Control to assist the physician in diagnosing and fol-

lowing cases of rheumatic fever. This Committee has the patient's and physicians' interests at heart and cannot function unless given the 'go ahead' by the attending physician. This is one Public Health activity directed and developed solely by practicing physicians.

"Your patient,....., has returned home to your care. Your Rheumatic Fever Center would be happy to assist you in the follow-up of this case. Such a follow-up, done only with your permission, would provide statistical data on cardiac disease and rheumatic fever and would also insist that the patient return to you and be kept under your personal care. Re-checks of this case will be gladly done for you from time to time if you desire.

"May we hear from you relative to your wishes in this matter.

"Fraternally yours,

.....M.D."

Chairman (Center)

9. Attempted to form liaison with the American Heart Association by numerous personal contacts and correspondence as finally exhibited by the following letter:

"Increased financial support for study and care of heart disease, of which rheumatic fever is a prominent part, is desirable.

"A national campaign to support this work is in preparation. The pioneering experience of the MSMS warrants that in any such program in this state, the MSMS should constitute the body through which the activity should be channeled, and that funds accruing from any campaign for the above-mentioned purposes be utilized under the direction of the Rheumatic Fever Control Committee and other appropriate committees of the MSMS and in the expansion and furtherance of their programs.

"This statement is contingent upon the understanding that a major portion of any funds raised in this state as a part of a national campaign shall remain in this State."

10. Established for future use a means of receiving monies donated for use in Michigan by using the Michigan Foundation for Medical and Health Education, Inc., as trustee.

11. Requested the appointment of a full-time medical co-ordinator.

12. Established very fine public relation with the Metropolitan Life Insurance Company whereby the program of the Michigan State Medical Society is adequately recognized in a film entitled "Be Your Age" which will be shown in Michigan theatres very soon.

The committee has continued to enjoy the fine support of the Michigan Society for Crippled Children and Disabled Adults and wishes to express its gratitude to the Society not only for financial aid but also for the splendid assistance and counsel of its Executive Director.

Respectfully submitted,
Frank Van Schoick, M.D., *Chairman*
N. E. Clarke, M.D.
Carleton Dean, M.D.
L. F. Foster, M.D.
Thomas Francis, Jr., M.D.
L. P. Ralph, M.D.
A. M. Roche, M.D.
H. H. Riecker, M.D.
C. J. Smyth, M.D.
Mr. P. C. Angove

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE—1947-48

While the Committee on Preventive Medicine held but one meeting during the year, its advisory groups met often, discussed a wide variety of problems in their respective fields and arrived at constructive conclusions of benefit to the public and the profession.

Of special significance are the following activities:

1. Support of a new bill before Congress regarding the status of iodized table salt.
2. Arrangements for the publication of the results of the Michigan Child Health Survey.
3. A detailed study of cancer detection centers.
4. Approval of a comprehensive diet manual to be published by the State Department of Health.
5. Discussion of proposed amendments to the State Commitment law and preparation of a medical history and physical examination outline for the general practitioner which will include a comprehensive application of psychiatric findings.
6. (a) A review of the present method of operation of tuberculosis case finding programs. (b) An effort to make more beds available for cases of tuberculosis and a request to the State Administration to provide more streptomycin for treatment of these patients. (c) Recommendation that a bill be introduced into the State Legislature making mandatory chest x-rays for all food handlers.
7. (a) A Venereal Disease conference program for general practitioners at Detroit on March 13, 1948. (b) Preparation of an outline of treatment for early and late syphilis. (c) Further review of laboratory examinations for diagnosis of syphilis offered by the State Department of Health. (d) Interpretation of laboratory procedures.
8. (a) Continued survey of maternal deaths in Michigan and proposed enlistment of county medical maternal health committees in this effort. (b) A review of existing state laws pertaining to therapeutic abortions and sterilization with consideration of necessary changes.
9. Activation of the numerous Rheumatic Fever Centers throughout the State.

More complete reports of the telling effort put forth by each of the advisory committees appears in this booklet and deserve attentive reading.

The committee is collectively grateful to the State Department of Health for its helpful co-operation.

Respectfully submitted,
W. S. Reveno, M.D., *Chairman*
J. K. Altland, M.D.
G. D. Cummings, M.D.
H. H. Cummings, M.D.
J. M. Dorsey, M.D.
H. H. Gay, M.D.
R. M. Kempton, M.D.
R. B. Kennedy, M.D.
C. E. Lemmon, M.D.
R. D. McClure, M.D.
R. M. McKean, M.D.
N. F. Miller, M.D.
H. M. Pollard, M.D.
L. W. Shaffer, M.D.
Frank Van Schoick, M.D.

ANNUAL REPORT OF COMMITTEE ON MENTAL HYGIENE—1947-48

Your Mental Hygiene Committee has held six meetings during the past year. It has been the expressed intention of the committee to continue and to advance the good work of the Mental Health Committees which have preceded it, and, in so doing, to pave the way for the further effort of the Mental Hygiene Committee for the next year. Although we have suffered from absenteeism, we understand the many urgent calls in the full life of the leading physician. Yet we feel under the necessity to represent forcefully the development of full attendance for this worthy cause of our group work.

Committee efforts have represented (1) extending responsibilities to our brother practitioners in the general and special fields of medicine, (2) compiling psychiatric data for neuropsychiatric history and examination procedure in general hospitals, (3) training of educators regarding the facts of mental health development, (4) working with legal and legislative groups to revise the laws dealing with psychiatric patients, (5) expanding effective relationships with associated societies dealing with mental health matters.

Your committee has observed with satisfaction the fruition of last year's committee work in setting up of a section on Psychiatry and Neurology in our State Medical Society. It has encouraged a systematic effort to further effective working relationships between the Michigan

Society of Neurology and Psychiatry and all other medical societies. It gave special consideration to the commitment laws pertaining to the mentally ill, and one of its members, Dr. Morter, has prepared a study on the topic for publication in THE JOURNAL. Its capital project has been the undertaking of the development of a neuropsychiatric history and examination outline for the special use of the general practitioner of medicine. The whole committee has functioned as a task force in this area. To Dr. Currier has been assigned the leading responsibility for sustaining interest and application on this main assignment.

While great progress has been made, much remains to be done by our medical profession in the cultivation of mental health centers for infants, children, and adults. Our great lack continues to be mobilized qualified personnel. Two committee members are working with our Medical Society's Commission on Health Care to develop the program of Medical Associates trained to function as medical aides.

The mental health insights of psychiatrists have advanced much farther than has the possibility of applying these accumulations of wisdom to the pressing mental health needs of the people. There is an increasing demand for this understanding to go to work on a larger scale. It is most essential that the simple truths of developmental psychology be made available to the people. The cause of mental hygiene is the cause of upholding full respect for the dignity of the human individual. No mind has ever been helped except through being respected in its development; no mind has ever been harmed except through being disrespected in its development. Innocence of this mental health principle constitutes the greatest misfortune of mankind.

Your committee has witnessed, and furthered participation in, distinguishing developments of mental health education, both locally and on a worldwide basis. Michigan Mental Health Week designated by Governor Sigler as the week of April 5 through April 12 focused attention on what communities are doing to increase the application of mental hygiene. The International Congress on Mental Health to be held in London August 11 to August 21, 1948, represents a sustained world effort to promote mental health. May consistent enduring action characterize our mental hygiene program for Michigan.

Respectfully submitted,
J. M. DORSEY, M.D., *Chairman*
R. G. BRAIN, M.D.
F. P. CURRIER, M.D.
M. W. HOFFMAN, M.D.
R. A. MORTER, M.D.
B. M. MURPHY, M.D.
R. P. SHEETS, M.D.
R. W. WAGGONER, M.D.

ANNUAL REPORT OF COMMITTEE ON RED CROSS BLOOD BANK PROGRAM—1947-48

The Committee on Red Cross Blood Bank Program has met with representatives of the Midwestern Area, American Red Cross, on three occasions relative to its plan to establish blood bank centers in Michigan, the latter being a part of its nation-wide program to develop and maintain an integrated system of blood procurement stations.

The past few years have been marked by a vast increase in the use of whole blood and its derivatives as a therapeutic and life-saving agent. During wartime emergency, the Red Cross has definitely established its ability to obtain and process large quantities of blood, and it is the opinion of its governing board that it can be of equal service to the nation on a peacetime basis. The possible urgent necessity of a pooling of resources could occur at any time, and it is the hope of the Red Cross to be prepared for such a contingency. The success of such a program depends largely upon a proper collaboration of local medical societies, hospital councils, and individual hospitals with the American Red Cross. The latter stands ready to render its services in such localities as need them; however, its policy is to enter only those communities where it is requested to do so by the local medical society.

It is the opinion of this committee that each county society should examine the adequacy of the blood supply in its area, whether for local peacetime use, or in time of disaster from any cause. The advisability of securing the advantages of a plan of such scope and possibilities rests entirely upon the local unit.

It is our opinion that the American Red Cross is the natural organization to conduct such a program, for it has the benefit of past experience in blood procurement through nation-wide organization, and possesses sufficient resources to carry it through to successful accomplishment.

Respectfully submitted,
R. S. MORRISH, M.D., *Chairman*
W. B. COOKSEY, M.D.
R. H. HOLMES, M.D.

ANNUAL REPORT OF MEDICAL LEGAL COMMITTEE—1947-48

No meeting of the Medical Legal Committee has been held during the past year. The function of this committee has been to act in an advisory capacity only and in conjunction with the Executive Secretary of the Society.

In our report last year we stated that advice had been given to one member of the Society who was threatened with a malpractice suit. This case involved alleged damage as the result of x-ray treatment administered with a diagnostic machine. The case came to trial but was settled during trial.

No other matters of medical legal nature were brought to the attention of the committee during the year.

Respectfully submitted,
S. W. DONALDSON, M.D., *Chairman*
C. E. LEMEN, M.D.
F. A. MERCER, M.D.
W. B. MITCHELL, M.D.
W. J. STAPLETON, JR., M.D.

ANNUAL REPORT OF THE COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION—1947-48

The Committee on Postgraduate Medical Education held two meetings, as usual, during the year 1947-48, the first on February 11, and the second on May 12, 1948. While only about one-half of the committee members were able to attend the meetings, the interest and enthusiasm of those attending were great. The extramural programs during the fall of 1947 and the spring of 1948 consisted of panel discussions. The program has been of this type for two years and, judging from the reports of the Councilors and many practitioners who attended, these panel discussions commanded much interest and were highly instructive.

The members of the Postgraduate Medical Education Committee, as well as the officers and members of the Michigan State Medical Society, wish to recognize the outstanding effort which was made by Dr. George J. Curry of Flint, and three of his associates, namely, Drs. Don L. Bishop, Hardy B. Elliott, and Harold W. Woughter. These men prepared and delivered a symposium on trauma, which was given in all of the teaching centers except their home city of Flint, and the five teaching centers in the Northern Peninsula. This symposium created wide interest throughout the state and was considered by the committee as an outstanding contribution to the Extramural Postgraduate Medical Education Program.

A few changes were made in the Extramural Postgraduate Medical Education Program in the Northern Peninsula. The center of Sault Ste. Marie, which was re-established on May 26, 1947, showed a splendid attendance at the spring meeting of 1948. The program usually held in Houghton was transferred to Calumet, where a more desirable place was available. The attendance was equally good. Also, Iron Mountain instead of Powers was used as a center. The change was made to relieve Dr. John Towey who for years has borne the burden of arranging the details for the meetings at Powers. This move was recommended by Councilor W. H. Huron and other physicians in that part of the Upper Peninsula. Special commendation should be given to Doctor Towey for his conscientious and valuable service in the program of Continuing Medical Education in the Upper Peninsula.

The medical subjects selected by the committee and given in the different teaching centers of the state are as follows:

AUTUMN, 1947

Panel Discussion: Recent Advances in Therapy
Panel Discussion: Trauma.

SPRING, 1948

Panel Discussion: Basis of Symptoms.
Panel Discussion: The Acute Abdomen.
Panel Discussion: Neoplasms.

A total of 1,173 doctors attended the teaching centers in the state. This was a decrease of forty-five doctors attending the meetings last year. About two years ago two of our oldest and well-established teaching centers annually showing a high attendance asked to have the postgraduate medical education programs separated from their regular county society meetings. The request was granted, but since that time the attendance has decreased markedly in both of these centers. This fact, in part, accounts for the lessened attendance. At the May meeting the Committee on Postgraduate Medical Education discussed fully the whole matter of interest in the State Society Programs, especially the decreased attendance in two centers. It was decided to contact these two centers by letter in order that their suggestions might be received and acted upon by the Committee. These communications have been sent out and copies of the replies will be mailed to each member of the Committee as soon as they are received by the Chairman.

The attendance record on the Extramural Centers was as follows:

Ann Arbor	91
Battle Creek-Kalamazoo	141
Bay City	78
Flint	148
Grand Rapids	119
Jackson	135
Lansing	122
Mt. Clemens	73
Saginaw	62
Traverse City	88
Upper Peninsula: Calumet, Iron Mountain, Ironwood, Marquette, Sault Ste. Marie	116
TOTAL	1,173

As in the past, teachers from both medical schools in the state took part in the teaching programs and in addition four outstanding specialists served as teachers. This information is given in the following table and list of names:

Wayne University College of Medicine	13
University of Michigan Medical School	23
Teachers affiliated with the Department of Postgraduate Medicine as Postgraduate Lecturers	4
TOTAL	41

Wayne

Clifford D. Benson, M.D.
Darrell Campbell, M.D.
Wyman C. C. Cole, M.D.
Ernest Gardner, M.D.
Ralph A. Johnson, M.D.
Richard M. McKean, M.D.
Harold C. Mack, M.D.
Aage Nielsen, M.D.
Harry A. Pearse, M.D.
William S. Reveno, M.D.
Charley J. Smyth, M.D.
Edward D. Spalding, M.D.
Edward Wishropp, M.D.

Michigan

Paul S. Barker, M.D.
Frank H. Bethell, M.D.
Jere M. Bauer, M.D.
Robert W. Buxton, M.D.
Kenneth N. Campbell, M.D
Frederick A. Coller, M.D.
Jerome W. Conn, M.D.
Moses M. Frohlich, M.D.
William J. Fuller, M.D.
A. C. Furstenberg, M.D.
Stanley I. Glickman, M.D.
Franklin D. Johnston, M.D.
Norman F. Miller, M.D.
Ralph M. Patterson, M.D.
H. Marvin Pollard, M.D.
William D. Robinson, M.D.
John M. Sheldon, M.D.
Cyrus C. Sturgis, M.D.
Harry A. Towsley, M.D.
Raymond W. Waggoner, M.D.
Ernest H. Watson, M.D.
Charles F. Wilkinson, M.D.
James L. Wilson, M.D.

Other

Don L. Bishop, M.D.
Hardy B. Elliott, M.D.
George J. Curry, M.D.
Harold W. Woughter, M.D.

The Second Annual Michigan Postgraduate Clinical Institute was held in Detroit on March 10, 11, and 12, 1948. The general outline of the program was similar to the one given in 1947. It was well received by the doctors of the state. The number of physicians attending in the three-day meeting was 1,157. The Committee on Postgraduate Medical Education last year recommended the annual repetition of this program. After two trial years it is the unanimous opinion of the Committee that this medical educational effort be permanently continued.

During the year 1947-48, forty Certificates of Fellowship and twenty-two Certificates of Associate Fellowship in Postgraduate Education were issued by the Society.

Intramural Activities

The attendance on the intramural courses at the University of Michigan Medical School follows:

Electroencephalography	2
Clinical Exercises for Practitioners	40
Clinical Internal Medicine	48
Electrocardiographic Diagnosis	121
Pediatrics	37
Orientation Course in Allergy	13
Application of the Basic Sciences to Clinical Medicine	16
Decentralized Resident Training Program	29
Second Annual Seminar in Urology	79
Surgical Pathology (Slides)	19
Anatomy	70
Refresher Course in Neuropsychiatry	5
Diseases of the Heart	37
Pediatrics	23
Metabolism and Endocrinology	27
Diagnostic Roentgenology	59
Otolaryngology Conference	39
Ophthalmology Conference	106
Diseases of the Blood	26
Diseases of the Gastro-Intestinal Tract	38
Allergy	24
Recent Advances in Therapeutics	21
Personal Courses (Interns, Assistant Residents, Residents, and Miscellaneous Registrations)	253
TOTAL	1,132

The registration on the above courses shows an increase of 139 physicians over the number attending last year. A total of 536 veteran physicians attended these courses.

A record of the Postgraduate Medical Education Program for the year 1947-48 at Wayne University College of Medicine is appended. This very active and useful program is serving a geographical area containing over one-half of the general practitioners of the state.

The committee takes this occasion again to thank the forty-one busy physicians who served as teachers in the Extramural Program. Their sacrifice and co-operation make possible the outstanding extramural postgraduate education program in Michigan. The committee hopes that some of the burden of teaching will be borne by other medical men in the state who are well qualified both in educational background and clinical experience to teach on this program. The committee wishes to express its thanks to the faculties of Wayne University College of Medicine and the University of Michigan Medical School for their wholehearted co-operation, and to the Michigan State Department of Health for its generous financial support of the lectures dealing with ob-

stetrics and pediatrics. Finally, the committee is proud of the continued interest and support of the Michigan State Medical Society and of its membership that make these programs possible.

WAYNE UNIVERSITY COLLEGE OF MEDICINE
Postgraduate Medical Education
June, 1947-June, 1948

	June Sept., 1947	Sept. Dec., 1947	Dec., 1947 March, 1948	March June, 1948
Number of doctors taking courses	11	131	110	116
Number of doctors who are veterans	7	92	72	71

Courses	*Quarters* June	Sept.	Dec.	March
Surgical Anatomy			13	10
Advanced Histology			3	
Regional Anatomy				23
Problems in Neurology				5
Newer Bactericidal Agents		18		
Medical Bacteriology			2	
Immunology and Virology				5
Parasitology				1
P. Chemistry Seminar		7	6	7
Survey of Med. Chemistry				16
Intermediary Metabolism				4
Nutrition and Metabolism				3
Dermatology Seminar		3	3	4
Conf. on Venereal Diseases		1		
Med. Pathologic Conf.	5	7	3	6
Med. X-Ray Conference	6	4	6	5
Allergy Clinic and Conf.	3	4	1	1
Electrocardiography		28	30	
Beginning EKG		5	1	
Diagnostic Conference			1	4
Gastroent. and Hematology Cl.		7	6	6
Endocrinology		33		
Survey of Physiology			31	
Survey of Pharmacology		7		
Physical Medicine				3
Beginning Hematology		11	3	6
Advanced Hematology		1		1
Surgical Pathology		35		
Neuropathology			10	
Pathology of Neoplasms			27	
Gynecologic Pathology				32
Anesth. Theory and Prac.			1	
Basic Ophthalmology (5 months' course)			12	
Child Guidance Clinic				1
Clin. Psychiatric Seminar				1
Neurologic Conference				5
Psychosomatic Conference				3
Beg. Physics in Radiology				2
Surgery Seminar		10	14	11

Respectfully submitted,
H. H. Cummings, M.D., *Chairman*
E. I. Carr, M.D., *Vice Chairman*
B. R. Corbus, M.D.
G. J. Curry, M.D.
W. B. Fillinger, M.D.
A. C. Furstenberg, M.D.
C. B. Gardner, M.D.
R. H. Holmes, M.D.
H. A. Kemp, M.D.
P. A. Riley, M.D.
J. M. Robb, M.D.
J. M. Sheldon, M.D.
E. D. Spalding, M.D.
F. A. Weiser, M.D.
C. P. Drury, M.D., *Advisor*
J. J. Walch, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL, 1947-48

Three regular meetings of the Venereal Disease Control Committee were held during the past year: on January 18 in Lansing, on June 6 in Lansing, and on July 10 in Bay City.

At the first meeting, the Chairman discussed the decrease in venereal disease in evidence in Michigan for the first time since 1939, and possible explanations for the decrease. The laboratory examinations for the diagnosis of syphilis offered by the laboratory of the Michigan State Health Department were reviewed and discussed. The following recommendations were made: that colloidal gold tests need not be done on otherwise negative spinal fluids; that routine cell counts should be made on all spinal fluids; that quantitative Kahn tests be done on all positive spinal fluid examinations, and that all laboratories in the state be encouraged to report quantitative tests in a uniform manner, preferably in units.

The advisability of a new program for revising and displaying new posters on venereal disease in public toilets was discussed. Arrangements have been made through the Michigan Department of Health to furnish 20,000 of these signs, prepared by the Michigan Bureau of Prison Industries; they will be distributed by the Michigan Liquor Control Commission to all licensees, and their display will be a condition of licensure.

A postgraduate program on the diagnosis and treatment of venereal disease, sponsored by the MSMS Venereal Disease Control Committee and the Michigan Department of Health was held at the Intensive Treatment Center, Herman Kiefer Hospital, Detroit, on March 13, 1948. Eight papers were given, and 159 physicians registered for the conference. This would seemingly show that physicians are interested in such presentations and that papers on the management of venereal disease should be included in future graduate conferences. The papers presented are to be published in an early special edition of The Journal of the Michigan State Medical Society.

At the second meeting further discussion was carried on with representatives of the laboratory of the Michigan State Health Department regarding facilities for more extensive use of quantitative serologic tests and special diagnostic procedures offered in cases suspected of having nonspecific reactions. Limited facilities make it necessary for the laboratory of the Michigan State Health Department to restrict such requests to an absolute minimum. It is requested that when financial means permit, such specimens should be sent to private laboratories. The Committee adopted a motion that the laboratories of the State Department of Health be requested to perform and report quantitative Kahn tests and complement-fixation tests on all positive marriage license examinations. The Committee suggests that such quantitative tests be performed by the same laboratory for more accurate interpretation.

The desirability of suggested outlines for the guidance of physicians on the most effective use of penicillin in the treatment of syphilis in its various stages and clinical forms was discussed at the first meeting. It was suggested that Drs. Curtis and Shaffer prepare such outlines. In spite of four years of experience with penicillin in the treatment of syphilis, only provisional outlines are as yet permissible. Instead of suggested outlines by our Committee which would be temporary and controversial in nature, it was decided to recommend the schedule prepared by the Syphilis Study Section, National Institute of Health for the Council on Pharmacy and Chemistry of the American Medical Association. The report entitled "The Status of Penicillin in the Treatment of Syphilis" appeared in the *Journal of the American Medical Association,* March 27, 1948, pp. 873-879. It is hoped to arrange for distribution of reprints of this article by the Michigan State Health Department to all members of the Michigan State Medical Society, together with a condensed outline of the schedules as prepared by the U. S. Public Health Service.

Respectfully submitted,
L. W. Shaffer, M.D., *Chairman*
R. S. Breakey, M.D., *Vice Chairman*
K. A. Alcorn, M.D.
A. C. Curtis, M.D.
W. B. Harm, M.D.
Ruth Herrick, M.D.
R. H. Holmes, M.D.
H. L. Keim, M.D.
E. S. Parmenter, M.D.
Frank Stiles, M.D.
O. D. Stryker, M.D.

ANNUAL REPORT OF SCIENTIFIC RADIO COMMITTEE, 1947-48

A meeting of the Scientific Radio Committee was held in Ann Arbor, Michigan, on December 2, 1947, at which time various policies were reviewed relative to the medical broadcasts being conducted from the University of Michigan campus. After considerable discussion of programs which had been presented in the past, it was agreed that these broadcasts were of valuable nature and that they should be continued.

It was, likewise, felt by the Committee that the increasing portion of the broadcast should be given by physicians not associated with the University of Michigan campus. As a result of the meeting, thirty-nine programs were arranged for 1947-48, to be continuous except for the summer months. Sixteen of these programs were to be prepared by doctors not affiliated with the University of Michigan and these physicians were to be selected by the Scientific Radio Committee. Twenty-three programs were to be prepared by physicians associated with the Medical School of the University of Michigan. It was further agreed that all speakers were to make arrangements with Mr. Waldo Abbott for their speech transcriptions, thereby making it possible for the talk to be broadcast from the campus in Ann Arbor, as well as from eight other radio stations throughout the State.

It was understood by the Committee that these programs were to be a program of the University of Michigan and broadcast with the co-operation of the Michigan State Medical Society.

Respectfully submitted,
H. M. Pollard, M.D., *Chairman*
D. K. Barstow, M.D.
R. E. Boucher, M.D.
T. T. Callaghan, M.D.
H. A. Kemp, M.D.
J. H. McMillan, M.D.
S. G. Meyers, M.D.
Kenneth Toothaker, M.D.

ANNUAL REPORT OF COMMITTEE ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND, 1947-48

This Committee has been rather inactive during the year. In a previous report it was recommended that County Medical Societies be stimulated to devote some time at one of their meetings to the objective of the High School Athletic Benefit Fund and to invite coaches and athletic directors to be present and to discuss their views on the subject. The Committee, last year, voiced its opinion that such action could be done on a local scale and to better advantage in order that both high school authorities and physicians might work together for the best interests of injured students. We have not received notice of any County Society having such a meeting.

A copy of the schedule of benefits effective for the 1947-48 school year was mailed to all physicians in the State.

This Committee recommended to the benefit plan that no allowance be made or benefits be paid for a fracture without x-ray evidence that a fracture did exist.

It was proposed by the Committee that the benefit plan adopt the Uniform Fee Schedule for Governmental Agencies but this proposal was rejected due to the fact that it would mean raising the present fees for each student, which, if enacted, would probably mean that a number of schools would drop the services of the benefit plan.

Respectfully submitted,
S. W. Donaldson, M.D., *Chairman*
L. Fernald Foster, M.D.
E. R. Witwer, M.D.

ANNUAL REPORT OF TUBERCULOSIS CONTROL, 1947-48

During this period, no problems were specifically referred to this Committee. At a meeting held on January 11, 1948, various matters pertaining to tuberculosis control were discussed.

The disproportion between the need for beds and the available supply was recognized and would appear to be in large measure due to lack of nursing personnel, rather than to lack of physical facilities or of funds. This shortage of nurses is not alone a problem of institutions for the tuberculous, but also of many general hospitals and is beyond the scope of the Committee.

While some comments have been made, unfavorable to the continued expenditure of funds in case-finding programs in view of the above shortage of beds, this was not concurred in by our committee and it was our opinion that this program should not only be continued but should be expanded so that all food-handlers should have chest x-ray.

Activities of the State Anti-Tuberculosis groups were a subject of discussion. The program of rehabilitation being sponsored by these groups is regarded as of great value to all people of the State and one of the important activities of these organizations.

The value of streptomycin in the management of various forms of tuberculosis is being increasingly demonstrated. Many questions remain to be answered and active support of programs aimed toward the solution of these questions is favored. We hope and expect that the legislature will continue to appropriate funds so that more Streptomycin will be available.

The Committee views with pride the continued high standing of Michigan in matters of tuberculosis control. Only further expenditure of energies in this direction will attain the distant goal when this disease will cease to be a major problem.

Respectfully submitted,
C. E. Lemmon, M.D., Chairman
J. L. Egle, M.D.
Cameron Haight, M.D.
P. J. Howard, M.D.
W. L. Howard, M.D.
H. G. Huntington, M.D.
G. T. McKean, M.D.
V. C. Johnson, M.D.
J. D. Littig, M.D.
E. J. O'Brien, M.D.
L. A. Pratt, M.D.
R. A. Rasmussen, M.D.
J. W. Towey, M.D.
B. R. VanZwaluwenburg, M.D.

ANNUAL REPORT OF COMMISSION ON HEALTH CARE, 1947-48

The Commission of Health Care has devoted time this year essentially to the promotion of Medical Associates, and to the development of the Brochure on Medical Associates which will be presented to the House of Delegates at the annual meeting.

We wish to call to your attention the need for further promotion of certain divisions and the urgent need for recruits in other divisions. To meet the health needs of America effectively requires increasing personnel. Effort to that end by the medical and dental professions will enhance our technical effectiveness, promote favorable public relations, and diminish the need for increasing compulsory, as against voluntary, insurance plans. Bearing in mind that 60 per cent of American families, according to the Brookings Institution, have incomes of $2,000 or less, let us continue our efforts to make this group self-supporting in health care through voluntary means by the medical profession. Medical Associates contribute to this possibility.

To assist in giving such service the needs for development in the various divisions of Medical Associates is indicated by the following data:

Nursing.—Total number of nurses needed in U. S. 359,500
Number now in profession.....317,800
Additional number needed..... 41,700
In Michigan employment vacancies 5,407

Medical Technologists.—Only 575 in Michigan. The Registry of Medical Technologists finds it possible to fill practically none of the positions that come to their attention, because they have no registrants listed.

Medical Artists.—At the present time the demand for medical illustrators seems to be greater than the available supply.

Occupational and Physical Therapists.—Existing Vacancies:

Civilian	261
Veterans Adm.	550
Navy	32
	843

Mental Health Associates.—The problem of mental health care has become so overwhelming that definite methods of action have not yet been formulated from the standpoint of Medical Associates training. This is an educational task without present possible means of fulfillment.

Medical Social Workers.—There is a much greater demand for Medical Social Workers than can be filled.

Hospital Dietitians.—At present there are 452 hospital positions open in the United States; 6 per cent of these are in Michigan—without any possibility at present of being filled. This is a decided educational concern of the House of Delegates of the Michigan State Medical Society.

Dental Associates.—

1. Dental Hygienists: 133 registered in Michigan; the demand exceeds the number of graduates.
2. Dental Assistants: 47.3 per cent of dentists employ assistants.
3. Dental Laboratory Technicians: Oversupply of trainees.

Leading dentists of Michigan estimated one year ago that through Dental Associates the distribution of dental care could be increased by 65 per cent. To be conservative, the Commission on Health Care gave an estimate of 50 per cent. It is of interest that without knowledge of either group knowing of this consideration given to the subject by the other, that the Brookings Institution estimated dentistry could be increased through Medical Associates by 62 per cent. And yet with 3,300 dentists in Michigan, there are only 133 Dental Hygienists in Michigan, and less than 50 per cent of the dentists have Assistants.

Medical Secretaries.—There is a constant demand for highly trained medical secretaries, and very little opportunity is provided for adequate training in Michigan.

Medical Record Librarians.—There are 1,936 registered record librarians in the United States to serve 6,500 approved hospitals.

Ophthalmic Associates.—This is another field in which the demand has increased beyond any specific organizational or educational development. Much of the work in this specialty is highly technical and can be done by trained technicians.

X-Ray Technicians.—Good x-ray technicians are always in demand; there is a shortage in communities with small hospitals.

Public Health Associates.—

1. Sanitary Engineer—Moderate need.
2. Industrial Hygienist—Critical need.
3. Health Inspector—most positions in Civil Service, but increasing number open in dairies, large food canners and packers.
4. Veterinarian—urgent need for all branches of Veterinary Medicine.
5. Vital Statistician—moderate need.
6. Public Health Educator—urgent need.

Hospital Administrators.—Shortage of trained hospital administrators in the United States. Approximately 200 hospitals in Michigan employ trained administrators. There is a turnover of approximately five to ten each year.

In the divisions of Ophthalmic Associates, Orthopedic Associates, and Associates to the Dermatologist, no courses are now offered except for Orthopedic Tehnicians and Chiropodists. Questionnaires sent out by the Commission indicate majorities of Ophthalmologists, Dermatologists, and Orthopedic surgeons voting for increased personnel in these divisions.

A report on the Medical Associates program has been made before the Michigan College Association, May 4, and the Department of Public Instruction through which it is receiving definite co-operation. Presentation of the program is received with much enthusiasm by young people in consideration of their entering these various fields, as evidenced by our first sampling of high schools in an address to Redford Union High School, June 3.

We believe it would be of definite value to all concerned were it possible to have a film made covering this subject, for use in motion picture theaters, high schools and colleges and through the Women's Auxiliary groups and before other interested organizations.

We recommend that the State Society give consideration through its Orthopedic Section to the immediate setting up of courses for Orthopedic Hygienists, or in lieu of this, to recommending the advising of Chiropody being developed to a university status.

The Department of Public Relations has done effective work this year in the development of Medical Associates. Its task in this regard is but partly accomplished. We recommend the continuance of the Commission on Health Care for the ensuing year. It becomes increasingly apparent that one of the best methods of dealing with irregular practice is to have all therapeutic procedures worthy to be classified as therapeutic, to be developed and given by the medical and dental professions.

Respectfully submitted.
R. H. Pino, M.D., *Chairman*
H. A. Kemp, M.D.
B. R. Corbus, M.D.
F. H. Drummond, M.D.
H. M. Pollard, M.D.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE, 1947-48

The Cancer Control Committee as a whole held two meetings during the year: one in November, 1947, in Ann Arbor, and one in March, 1948, in Lansing. However, the three subcommittees, into which the committee membership has been divided in order to facilitate consideration of various problems falling within the scope of the Committee's activities, held meetings to consider matters referred to them by the whole committee.

The subcommittee on Education held two meetings and continued its study of professional education. On request, the editor of The Journal, Michigan State Medical Society, kindly placed a page of each issue at the disposal of the Cancer Control Committee for bringing to the physicians of Michigan pertinent information about the cancer problem. This page is entitled "Cancer Comment" and appeared for the first time in the April, 1948, issue of The Journal.

The Cancer Control Committee has taken active steps to continue the *Michigan Cancer Bulletin* for an indefinite period. Volume II will be written entirely by Michigan doctors, twenty physicians having accepted the committee's invitation to prepare articles on cancer of various organs. Many of these articles are now in the printer's hands and their distribution at monthly intervals will begin later in the year.

The Michigan Cancer Program, a brochure discussing

the cancer problem in Michigan and means being taken to cope with it, was distributed to members of the Michigan State Medical Society, the Michigan Pharmaceutical Association, and the Legislature; also to all local health departments and organizations of the American Cancer Society. Plans are under way for its distribution to dentists, nurses and other interested groups. Twenty-five thousand copies have been distributed.

Upon the suggestion of this committee, the School of Public Health, University of Michigan, in January, 1948, held a three-day Cancer Institute for health officers and supervising public health nurses. Speakers of national prominence appeared on the program. This Institute was the first of its kind held in a school of public health in this country and drew an attendance of more than 150, the majority of whom were Michigan health workers. This meeting was followed by a seven-day refresher course in cancer nursing for twenty-one public health nurses. The course for nurses was repeated during the summer session.

Each county medical society has again been urged to appoint a cancer committee and to hold a cancer-teaching day or at least to devote one meeting to cancer subjects each year. Cancer teaching days have been held in Flint, Grand Rapids, Kalamazoo, Battle Creek, Hastings, Niles, and St. Joseph-Benton Harbor. The postgraduate team visiting the Upper Peninsula in May, 1948, devoted one session at each meeting to a discussion of problems of malignancy. In addition, a special meeting of physicians and dentists in Dickinson and Iron counties was devoted to cancer. Similar meetings have been held in Hillsdale, Barry, and Clinton counties.

While the Ways and Means subcommittee held no meeting during the year, it did gather pertinent information regarding the source and amount of funds available for cancer control work in the State. So far as could be determined, the funds of local organizations of the American Cancer Society are being spent in a constructive manner as the needs of their communities dictate.

The Fact-Finding subcommittee held one meeting during the year at which time the study outline used in the pilot surveys noted in last year's committee report was revised in keeping with experience gained in its use in the field. This outline is now available to any local medical group wishing to make a similar survey of its own cancer problem.

The Fact-Finding subcommittee also has developed an outline for the study and evaluation of cancer detection centers in Michigan. It is proposed to make this survey within the next few months out of which it is expected that some general principles governing the conduct of these organizations may develop.

Cancer detection centers are now reported in operation in Bay City, Battle Creek, Detroit, Grand Rapids, Hastings, Lansing, Marquette, Menominee, Pontiac and Saginaw. Conferences regarding cancer detection centers have been held with groups of physicians in Howell, Niles, Ironwood, Marquette and Saginaw. Several other local medical and lay groups have inquired about providing such facilities for their communities.

As a result of the study of cancer incidence and prevalence made in Hillsdale County last year, the medical society of that county has set up the "Hillsdale Plan" for the detection of cancer. Each physician has offered to the women of that county, forty years of age and older, an examination of their skin, breasts, cervix and rectum; the examination to be made in the doctor's offices during hours and for their regular fee. The county health department keeps a master file of all examinees. The examinations are to be repeated semiannually.

While this plan has been in operation only since January 1, 1948, it is proving acceptable to both physicians and laymen and is attracting attention throughout Michigan and surrounding states. Far more periodic examinations are being made than heretofore and as high a percentage of malignancy is being found as is reported from special cancer detection centers in other parts of the country. The physicians of Hillsdale County are demonstrating that it is practicable to make every physician's office a cancer detection center.

On request of the Cancer Control Committee, the Michigan Pathological Society appointed a committee to study and evaluate the cell smear (Papanicolou) test for early cancer.

The secretary's office has answered inquiries about the Michigan cancer program from many parts of the country. Assistance has also been given to several local groups within the state. Insofar as possible, all such requests have been complied with. Members of the Cancer Control Committee have rendered valuable service to the cancer work in their own communities.

Support of the committee's work by the co-operating organizations, the Michigan Division, American Cancer Society, the Southeastern Michigan Division, American Cancer Society, and the Michigan Department of Health, also a substantial contribution from the Kellogg Foundation, is gratefully acknowledged.

The Cancer Control Committee urges increased emphasis in the attack on local cancer problems by professional and lay groups most concerned. It plans to continue the present program and to put special emphasis on making every physician's office a cancer detection center.

Respectfully submitted,

N. F. Miller, M.D., *Chairman*
P. L. Ledwidge, M.D., *Ex-officio*
F. A. Coller, M.D., *Advisor*
F. L. Rector, M.D., *Secretary*
J. K. Altland, M.D.
Max Burnell, M.D.
D. C. Burns, M.D.
L. A. Campbell, M.D.
E. I. Carr, M.D.
A. E. Hammond, M.D.
Eugene Hand, M.D.
L. E. Holly, M.D.
A. A. Humphrey, M.D.
W. A. Hyland, M.D.
C. H. Keene, M.D.
H. F. Mattson, M.D.
A. B. McGraw, M.D.
H. L. Miller, M.D.
H. M. Nelson, M.D.
C. A. Payne, M.D.
H. M. Pollard, M.D.
H. W. Porter, M.D.
H. R. Prentice, M.D.
W. W. Sawyer, M.D.
H. L. Sigler, M.D.
H. L. Smith, M.D.
H. J. Vanden Berg, M.D.

ANNUAL REPORT OF PUBLIC RELATIONS COMMITTEE, 1947-48

The Public Relations Committee has grown to a Committee of thirty-nine members, representing each of the Michigan State Medical Society Councilor Districts, and providing personnel for the Media Committees whose reports follow this review of the over-all activity of the parent committee.

Personal Contact

Personal contact with lay organizations, communication media and personnel, medical organizations, health and educational organizations, important individuals in the business and professional world, governmental workers and policy makers cannot be spelled out in specific terms. Suffice it to say that this year has seen a definite increase in personal contact activity on the part of those who are interested in the public relations of organized medicine.

Co-Planning

In regard to the thinking which has determined the policy and activity of Michigan State Medical Society Public Relations, it must be reported that a tremendous amount of time and thought has been placed on this subject. This is true not only of doctors and their employes. In addition, the friendly counsel of hundreds of people in ancillary organizations, in the fields of communication, advertising, education, and others, has been encouraged with excellent results. This is epitomized by the action following the first annual Rural Health Conference held at East Lansing on September 18-19, 1947. The net result of the Conference was to place the medical profession in a position of leadership in rural health activities with a progressive plan which was taken up and followed with enthusiasm by the thirty organizations who co-sponsored the Conference. This has developed both co-operation from and acceptance of Medical Society information by the organizations themselves and by the various newspapers and magazines. This is most gratifying and has done much to place the Michigan State Medical Society in a favorable light with leaders and molders of public opinion.

Indications of Progress

Scrap books are not proof of good Public Relations, but they are indicative of interest and support. The clippings and other reports in the possession of the Michigan State Medical Society indicate that during the past two years more favorable words have been written, spoken and published regarding the Michigan State Medical Society and its membership than in the previous fifteen years added together.

It is important to note that the activity of several other important state medical societies has not only been patterned after, but has actually used the output of Michigan Public Relations to good effect and with gratitude.

Public Speaking

Arrangements have been made throughout the year for addresses to be given to various organizations outside of the medical profession such as Service Clubs, Womens Clubs, Educational Associations, Rural groups, et cetera. For these, the Public Relations Committee has either provided the speakers from its membership or obtained satisfactory representatives.

Displays

Displays of a Public Relations nature at both the Annual Session of the Michigan State Medical Society and the American Medical Association have been arranged. In addition, these exhibits are being placed before the public through County Medical Societies and other organizations.

Awards

Awards have been given to the W. K. Kellogg Foundation; Emory W. Morris, Battle Creek; Henry Vaughan, Ann Arbor; Donald E. Johnson, Flint; for outstanding health service, and a new award, "Michigan's Foremost Family Physician," was presented to T. E. DeGurse, M.D., Marine City. These awards have, in each case, served to honor the recipient and keep the Michigan State Medical Society in a position of leadership.

Co-operation with Intra-Organizational Groups

A major part of any public relations effort is to correlate the work of various other committees when their work deals directly with the public, since this work thereby becomes a very definite part of the Public Relations program: Below are some indications of the work done in this regard.

Commission on Health Care:—Activity in connection with this Commission has amounted to aid in the development of the brochure on Medical Associates, preparation of visual and auditory aids on the program, contact with schools and school organizations—colleges and college organizations, organization of a plan for dissemination of information re the program, and investigation of the need involved.

Committee on Rural Medical Service:—The Public Relations Committee has worked closely with this Committee in the development and production of the first annual Michigan Rural Health Conference and in the preparations for the second annual Rural Health Conference.

Health Survey Advisory Committee:—The Michigan Health Survey is being developed by this Committee with the co-operation of the Public Relations Committee so that, in addition to the obtaining of medical needs data, information will be found on attitudes and opinions of interest to the MSMS from the standpoint of public relations. The survey is state-wide in nature and is based on the master sampling procedure developed by Iowa State University. It is being conducted by the Social Research Service of Michigan State College.

Committee on Rheumatic Fever Control:—Publicity in newspapers and magazines of a most effective and widespread variety has been given this Committee as a part of the public relations program. The Metropolitan Life Insurance film, "Be Your Age," was credited to MSMS and arrangements made for 90,000 copies of the pamphlet "Your Child is Safer in Michigan" to be printed and disseminated with the showing of the picture in moving picture theaters.

Committee on Scientific Radio:—Arrangements were made through the Committee to utilize speakers from localities outside of Ann Arbor and to place the program "Medical Talks" on additional radio stations.

Legislative Committee:—The Public Relations Committee has acted with this Committee to bring a fuller knowledge of the principles and practices of the MSMS membership to the members of the Legislature.

Committee on Awards:—The work of the Public Relations Committee has been efficacious in causing widespread recognition to be given to those who have been honored by the Committee on Awards.

Woman's Auxiliary:—Liaison in public relations activity, was established with the Woman's Auxiliary to the end that several meetings of women's groups were held presenting speakers on medical socio-economic subjects this year and a very definite and complete program outlined for 1948-49.

Michigan Foundation for Medical and Health Education, Inc.:—This Foundation, in addition to their other activities, has seen fit to join with the MSMS in co-sponsoring the Michigan Health Survey, the Michigan Rural Health Conference, and the showing of the motion picture "Be Your Age." They have also set up a Loan Fund for the Encouragement of Practice in Rural Areas. These activities have tied in closely with the public relations program and work of the Public Relations Committee.

National Organizations:—Attendance, participation, and co-operation in programs of the American Medical Association, the National Conference on Medical Service, the National Rural Health Conference, and national specialty groups have been carried out to the fullest extent.

Advice and Assistance in Public Relations

The work of the Public Relations office has increased to the extent this year that an additional assistant, H. W. Corsette, was given to Hugh W. Brenneman, Public Relations Counsel, to aid him in forwarding and implementing the desires of the Committee.

Wallace-Lindeman, Inc., of Grand Rapids, has continued to serve as advertising counsel with excellent advice and assistance.

Jam Handy Organization in Detroit has served as consultant in visual and auditory aids as well as producing the MSMS moving picture.

Two years ago a long-time Public Relations Program was designed, and the Program this year has merited the confidence of the House of Delegates and The Council by developing effectively in every phase of Public Relations work so that the effort of the Society has become well organized, accurately directed and enthusiastically developed.

The instructions of the House of Delegates have been carried out, and all actions of the Public Relations Committee have been thoroughly reviewed by the Executive Committee of The Council, which has authorized the expenditure of funds only after exhaustive review.

Respectfully submitted,

Public Relations Committee

L. W. Hull, M.D., *Chairman*
C. L. Candler, M.D.
G. T. Aitken, M.D.
E. W. Blanchard, M.D.
A. F. Bliesmer, M.D.
A. S. Brunk, M.D.
J. S. DeTar, M.D.
Douglas Donald, M.D.
L. Fernald Foster, M.D.
N. J. Frenn, M.D.
W. G. Gamble, Jr. M.D.
W. J. Herrington, M.D.
L. T. Henderson, M.D.
L. E. Holly, M.D.
Kenneth Johnson, M.D.
W. S. Jones, M.D.
C. R. Keyport, M.D.
J. S. Lambie, M.D.
J. J. Lightbody, M.D.
J. E. Livesay, M.D.
J. J. McCann, M.D.
H. J. Meier, M.D.
E. B. Miller, M.D.
F. J. O'Donnell, M.D.
E. S. Oldham, M.D.
E. A. Osius, M.D.
C. A. Payne, M.D.
F. R. Reed, M.D.
E. S. Rhind, M.D.
W. Z. Rundles, M.D.
R. F. Salot, M.D.
G. B. Saltonstall, M.D.
A. E. Schiller, M.D.
A. H. Steele, M.D.
R. W. Teed, M.D.
Arch Walls, M.D.
C. L. Weston, M.D.
D. B. Wiley, M.D.
G. A. Zindler, M.D.

ANNUAL REPORT OF COMMITTEE ON CINEMA, 1947-48

The Committee on Cinema met on January 24, April 23, and again on May 10, to draw up final plans for integrating motion pictures with the master public relations plan of the MSMS. The following progress has been made:

1. The Michigan State Medical Society motion picture was prepared under the direction of this committee. The picture stresses the greater life expectancy of a child born today as compared to that of one born fifty years ago. It shows how because of modern immunization procedures and the swift advance of medical science the average person today may look forward to a life expectancy of sixty-five plus. It emphasizes the work that the MSMS has done in controlling disease.

The picture, filmed by the Jam Handy Organization in Detroit, runs ten minutes in length and will be distributed through the motion picture theaters of Michigan. It is anticipated that over a million persons will see it on screen.

2. Arrangements were made whereby the Metropolitan Life Insurance Company's ten-minute motion picture "Be Your Age" was shown in Michigan theaters with a trailer outlining the Rheumatic Fever Control Centers; namely, the Michigan State Medical Society, The Michigan Foundation for Medical and Health Education, the Michigan Society for Crippled Children and Adults, as well as the State Department of Health.

Over 90,000 copies of the pamphlet "Your Child is Safer in Michigan" were distributed to theater audiences at the time this picture was shown in Michigan theaters.

Respectfully submitted,

Arch Walls, M.D., *Chairman*
A. E. Schiller, M.D.
E. A. Osius, M.D.
J. S. DeTar, M.D.
R. F. Salot, M.D.

ANNUAL REPORT OF COMMITTEE ON PUBLIC RELATIONS PUBLICATIONS, 1947-48

A meeting of the Committee on Public Relations Publications was held on January 24. The publications put out in 1947 were reviewed, and the matter of future publications discussed. Following is a report on the activities of the committee:

1. The Medical Associates brochure was completed, published, and prepared for distribution to schools and colleges through the MSMS and the Woman's Auxiliary of the MSMS. This brochure has been developed for the purpose of stimulating the recruitment of young people into fields allied with health and medicine.

Each page in the brochure is devoted to a different Medical Associate Field. These pages are introduced with pictures showing the particular associate in his professional habitat. The accompanying article is designed to attract the interest of the high school or college student to that particular occupation. Detailed information on each of the professions outlined throughout the book is contained in a large chart at the back of the brochure.

2. Medical Plan for Michigan, a publication outlining the work of the Michigan State Medical Society, has been revised and prepared for distribution. This publication is designed to give a comprehensive over-all description of the various health and medical activities carried out by the Michigan State Medical Society at the present time.

3. A brochure reporting the activities of the first Michigan Rural Health Conference was published along with a supplementary report which outlined the steps taken to implement the resolutions which were passed at the Conference. Copies were distributed throughout Michigan, and 1,000 copies were distributed at the AMA Convention held in Chicago in June.

4. Feature articles were prepared for each issue of The Journal. These articles were then reprinted and mailed to governmental officials and representatives and to officers and public relations committee chairmen of the county societies. By this means, interested parties are kept posted on the latest socio-economic activities of organized medicine in Michigan.

5. A new monthly bulletin, PR BYLINES, was sent to all members of the MSMS. PR BYLINES is a service which the Public Relations Committee feels is needed as a supplement to The Journal, which must, of necessity, confine itself to more weighty and scientific discourse.

6. A public relations column "PR in Practice" is published in each issue of The Journal. This column is designed to give a broad over-all picture of the month's public relations activities.

Respectfully submitted,

Kenneth Johnson, M.D., *Chairman*
A. F. Bliesmer, M.D.
L. Fernald Foster, M.D.
J. E. Livesay, M.D.
L. T. Henderson, M.D.

ANNUAL REPORT OF COMMITTEE ON RADIO, 1947-48

The Committee on Radio met on January 24 and formulated plans and policies for utilizing radio time to the best possible advantage. Following is a report of the activities which were planned and carried out:

1. The "Tell Me, Doctor" program was continued this year and is now being broadcast over the following twenty-two Michigan stations: WELL Battle Creek, WHLS Port Huron, WJIM Lansing, CKLW Detroit, WKZO Kalamazoo, WATT Cadillac, WMIQ Iron Mountain, WLAV Grand Rapids, WDMJ Marquette, WIBM Jackson, WTCM Traverse City, WATZ Alpena, WHDF Calumet, WMPC Lapeer, WMBN Petoskey, WMRP Flint, WHFB Benton Harbor, WOAP Owosso,

WJPD Ishpeming, WBCM Bay City, WDBC Escanaba, and WHRV Ann Arbor. This makes a total of 5,720 separate individual broadcasts being heard in a single year in Michigan: Total sixty-minute radio hours: 477.

This program is also being used regularly over four stations in Virginia by the Medical Society of Virginia. The stations over which it is heard are WINC Winchester, WLVA Lynchburg, WBTM Danville, and WOPI Bristol. The Kanawha County Medical Society presents the program over WCHS Charleston, W. Virginia, and it is also broadcast by the Oklahoma State Medical Society over two major stations.

2. The University of Michigan program "Medical Talks" is broadcast in co-operation with the Michigan State Medical Society. It consists of thirty-nine fifteen-minute transcribed broadcasts by doctors of medicine and is heard over nine stations for a total of 351 separate individual broadcasts. (See report of Scientific Radio Committee).

3. Special broadcasts were presented from time to time such as the seven broadcasts during the MSMS Annual Session, special broadcasts at the Michigan Rural Health Conference, those presented on immunization over station WKAR E. Lansing, and others.

4. News releases are routinely used by radio stations at the same time they are released to newspapers.

5. *Radio Use by Local Organizations:*—Several county medical societies sponsor or approve local radio programs. Among them are:

Wayne County Medical Society: Edits script "To Your Industrial Health" for the UAW-CIO Health Institute which is heard over WWJ Detroit.

Muskegon County Medical Society: Presents a fifteen-minute program "Why do You Worry" each Tuesday over Station WKBZ.

Washtenaw County Medical Society: Uses thirteen AMA transcriptions on nutrition over WPAG Ann Arbor. In addition this society co-operates with Beyer Hospital in the presentation of a weekly program with general practitioners giving fifteen-minute talks.

Ingham County Medical Society: Utilizes radio in the releasing of news items for PR functions. The society also co-operates in a weekly fifteen-minute program sponsored by a local drug firm.

Berrien County Medical Society: A local MSMS doctor of medicine gives a weekly ten-minute talk on health and medicine over WHFB Benton Harbor, carried as a sustaining program by the station.

Bay County and Gogebic County Medical Societies: Use local radio facilities for special programs.

Respectfully submitted,
C. A. Payne, M.D., *Chairman*
C. L. Candler, M.D.
W. G. Gamble, Jr., M.D.
R. W. Teed, M.D.
W. J. Herrington, M.D.

ANNUAL REPORT OF COMMITTEE ON NEWSPAPERS, 1947-48

The Committee on Newspapers held a meeting on January 24 to make plans for the part which newspapers would play in implementing the over-all public relations program. As a result of this meeting the following steps have been taken:

1. *Advertisements:*—Four ads were placed in forty-nine daily newspapers and fifty-six weekly newspapers in Michigan, as well as in the *Michigan Farmer* magazine. This makes a total of 426 ads (with a total reading circulation of approximately 1,750,000) which were seen by the people of Michigan during the course of the year.

2. *Newspapers:*—Advance newspaper releases were sent to all newspapers in Michigan on the Michigan Postgraduate Clinical Institute, the Michigan Rural Health Conference, and the MSMS Annual Session, and received universal acceptance. Special releases on all speakers at these meetings were sent out to local newspapers. In addition, releases were distributed on miscellaneous unscheduled events such as addresses before groups by individual physicians, awards and presentations to those honored by the MSMS, and special news features which were felt to be of interest to the general public. The naming of Michigan's Foremost Family Physician received particular attention.

3. *Feature Releases:*—Feature articles with pictures were written and released through the *Detroit News, Detroit Times, Grand Rapids Herald, Grand Rapids Press, Michigan Times, Kalamazoo Gazette, Battle Creek Enquirer and News, Bay City Times, Chicago Daily Tribune, New York Times,* and others. The *Michigan Farmer, Country Gentleman,* and *Science Illustrated* have carried special features.

Special releases such as the one on the Rheumatic Fever Centers (three columns with pictures) were sent out in mat form to all newspapers. These articles appeared in an average of 195 Michigan papers.

4. *Health News Column:*—The Health News Column continues in popularity. Written to appeal to the lay reader, this column features the latest developments in the health and medical fields. Sent out weekly in mat form, it is carried regularly in 253 Michigan newspapers.

Respectfully submitted,
C. L. Weston, *M.D., Chairman*
J. J. Lightbody, M.D.
H. J. Meir, M.D.
F. J. O'Donnell, M.D.
G. T. Aitken, M.D.

ANNUAL REPORT OF COMMITTEE ON EDUCATION PROGRAMS IN SCHOOLS AND UNIVERSITIES, 1947-48

At a meeting of the Committee on Education Programs in Schools and Universities held in Detroit on January 24, needs and proposed solutions for educational problems were presented and discussed. Following is the action taken on the suggestions of the committee:

1. Progress has been made on the Sex Education Program. Sixteen scripts have been completed, and are being transcribed on fifteen-minute records. Eleven minutes of each record are devoted to the dramatization of a specific phase of sex education and four minutes to a scientific explanation of the subject dramatized.

The transcriptions are being recorded by Wayne University, and will be tried out in typical high schools this fall. If they prove acceptable, they will be offered to all high schools in the state.

An explanatory teacher's guide has been prepared which will accompany the transcriptions. This will make it unnecessary for an M.D. to be in the classroom to present the subjects, as has previously been the case, yet the service will be one that is offered by doctors of medicine.

Respectfully submitted,
D. B. Wiley, *M.D., Chairman*
E. B. Miller, M.D.
J. S. Lambie, M.D.
J. J. McCann, M.D.
A. H. Steele, M.D.

ANNUAL REPORT OF COMMITTEE ON HEALTH EDUCATION CONFERENCE, 1947-48

This Committee met on January 24 making several recommendations adopted by the MSMS Public Relations Committee. However, it has no activity to report since the function of the committee as per its original purpose no longer exists.

Respectfully submitted,
W. Z. Rundles, M.D., *Chairman*
W. S. Jones, M.D.
L. E. Holly, M.D.
C. R. Keyport, M.D.
N. J. Frenn, M.D.

MICHIGAN STATE MEDICAL SOCIETY

Technical Exhibits

Detroit, September 22-24, 1948

Abbott Laboratories — **Booth No. 31**
North Chicago, Illinois

You will be interested in viewing the brand new display prepared for this meeting. A wide variety of research specialties will be on view and your questions will be welcomed by the Abbott professional representatives in attendance. Make a visit to the Abbott booth a *Must* on your program.

A. S. Aloe Company — **Booth No. 34**
St. Louis, Missouri

Representatives of the A. S. Aloe Company will welcome their friends at Booth No. 34 where they will have on display a representative cross section of a complete line of Surgical, Hospital, and Laboratory equipment and supplies. Featured will be a complete line of government surplus instruments available at the present time—especially selected, fully certified instruments at approximately one-half the regular cost.

Ames Company, Inc. — **Booth No. 13**
Elkhart, Indiana

Ames Company representatives will be glad to discuss Decholin, the standard hydrocholeretic agent for the treatment of biliary tract diseases; and Decholin Sodium, pure sodium dehydrocholate.
They will be demonstrating Clinitest and Hematest—simplified tests for the detection of urine-sugar and occult blood.

Armour Laboratories — **Booth No. 12**
Chicago, Illinois

The Armour Laboratories, a pioneer in the field of endocrinology, will welcome members of the Michigan State Medical Society to visit the Armour exhibit in Booth No. 12. If you have not received copies of Armour booklets on

"The Thyroid Gland"
"Function and Malfunction of the Biliary System" and
"Armour Atlas of Hematology"

you may secure them at the Armour booth.

Ayerst, McKenna & Harrison, Ltd. — **Booth No. 11**
New York, New York

"PREMARIN" (Estrogenic Substances—water-soluble)—a highly effective and well-tolerated preparation of naturally occurring, orally active, conjugated estrogens (equine). The potency of "Premarin" is expressed in terms of its principal estrogen, sodium estrone sulfate.
"Premarin" is provided in four potencies of tablets and also in liquid form.

Baker Laboratories — **Booth No. 9**
Cleveland, Ohio

Baker's Modified Milk, liquid or powder, may be used interchangeably from birth to the end of the bottle-feeding period. An adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron, coupled with simplicity of preparation and low cost, provide for complete nutrition and insure co-operation in the home.

Bard-Parker Company, Inc. — **Booth No. 41**
Danbury, Connecticut

Bard-Parker RIB-BACK surgical knife blades; surgical knife handles, including long handles for deep surgery, laboratory handles, and hysterectomy and eye handles; Bard-Parker Germicide—a sporicidal solution; instrument-sterilizing containers; *Chlorophenyl,* an ideal office instrument disinfectant; hematological cases for obtaining bedside blood samples and pipettes.

Barry Laboratories, Inc. — **Booth No. 23**
Detroit, Michigan

The Barry Laboratories will display for the consideration of their many physician friends new and modern diagnostic allergy skin-testing sets. There will be assortments for all specialties, including a special assortment for the general practitioner. In addition, the allergy division will present a personalized treatment method as used for the specific desensitization of allergy patients.

The Biological Division of the Barry Laboratories will present a complete line of sterile injectables in multiple dose and ampule vials, including a high potency ready mixed B-Complex solution with a long-term potency guarantee. The technical representative of the Barry Laboratories will be on hand to assist all physicians inquiring about their products and services.

The Borden Company — **Booth No. 48**
New York, New York



Your attention is invited to PROTOLAC, a new especially formulated blend of intact proteins and high protein products derived from animal and vegetable sources. PROTOLAC is supplemented with choline and the amino acid cystine. PROTOLAC is indicated in high protein therapy in conditions requiring increased dietary protein of optimum nutritional value.
Likewise exhibited will be the long established Borden products for infant feeding: BIOLAC, DRYCO, MULL-SOY, MERRELL-SOULE SPECIAL MILKS, general purpose KLIM, and BETA LACTOSE.

Brewer & Company, Inc. — **Booth No. 68**
Worcester, Massachusetts

This exhibit consists of specialties, centering around Thesodate, the original enteric-coated tablet of Theobromine Sodium Acetate and Luasmin, a combination of Theophylline Sodium Acetate, Phenobarbital and Ephedrine for the treatment of asthma. Also, Brewer Capsules and Ampuls, other specialties including Soduxin (Sodium Succinate—Brewer) and standard pharmaceuticals manufactured by Brewer & Company, Inc., including a complete line of Vitamin preparations for internal use and injection. Gel-ets, the newest mode in oral vitamin therapy, and Brewer's newest item, Amchlor, a one-gram enteric coated tablet of Ammonium Chloride, are also featured.

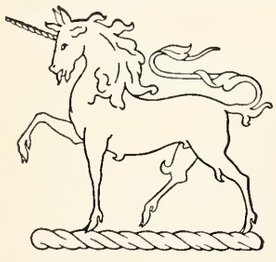
Brooks Appliance Company **Booth No. 18**
Chicago, Illinois

The BROOKS APPLIANCE COMPANY will have on display a complete line of Bandages, Proctological Instruments, Syringes, Needles and Elastic Stockings. W. C. Ayer will have charge of the exhibit and will describe in detail the technique of applying the new combination pressure bandages, Contura plus Pressoplast, which is used in treating Phlebitis, Leg Ulcers and Osteo-arthritis of the knee joints.

Burdick Corporation **Booth No. 16**
Milton, Wisconsin

The Burdick Corporation will feature their new F.C.C. approved Diathermy Unit, Model X 85. They will also show their complete line of Infra-red and Ultra-violet Lamps, Muscle Stimulator, and the Rhythmic Constrictor for treating peripheral vascular conditions.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth No. 50**
New York, New York



Among significant products featured will be WELLCOME GLOBIN INSULIN, which provides an action which is timed to be more suitable for the average diabetic; DEXIN brand High Dextrin Carbohydrate, in which the nonfermentable proportion predominates; DIGOXIN, the pure, stable, crystalline glycoside which offers predictable digitalization; and METHEDRINE, a recent sympathomimetic drug of wide therapeutic application.

Camel Cigarettes **Booth Nos. 38, 39**
New York, New York

CAMEL Cigarettes will present a dramatic full-color review of their recent medical research on smoking, as well as the details of the nation-wide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

Cameron Heartometer Company **Booth No. 54**
Chicago, Illinois

See the improved Heartometer, a scientific precision instrument for accurately recording systolic and diastolic blood pressures, also furnishing a permanent graphic record of the pulse rate, disturbances of the rhythm, myocardial response, the action of the valve, as well as peripheral vascular circulation. The Heartometer clearly reveals heart disturbances in both early and advanced stages, and is of great value in checking the progress of medication and treatments.

Cameron Surgical Specialty Company **Booth No. 49**
Chicago, Illinois

Have a demonstration of the Cameron Cauterodynes and Cauteradios for electro-surgery, electro-cauterization and electro-coagulation; Telescopic Bronchoscopes —Esophagoscopes—Laryngoscopes; Coagulair-Sigmoidoscope; Electro-Diagnostic Lamps and Instrument Sets; Radiolucent Cannula; the new Flexible Gastroscopes with treated and coated lenses; Flexible Esophagoscope; Mirror Headlites; Binocular Spectacle Loupe; Magniscope and other specialties.

Carnation Company **Booth No. 22**
Los Angeles, California

You are invited to visit Booth No. 22 where you will see an attractive display on Carnation Evaporated Milk—"the milk every doctor knows." Some valuable information on the use of this milk for infant feeding, child feeding, and general diet will be presented and the method by which Carnation is generously fortified with pure crystalline Vitamin D-400 U.S.P. units per reconstituted quart will be explained. Interesting literature will also be available for distribution.

Ciba Pharmaceutical Products, Inc. **Booth No. 35**
Summit, New Jersey

The Ciba exhibit of "Economical Hormone Therapy" will feature METANDREN Linguets, the most potent oral androgen in tablets, designed for absorption through sublingual mucosa; LUTOCYLOL Linguets, orally effective progestogen especially designed for sublingual absorption; and ETHINYL ESTRADIOL, the most potent oral estrogen.
Representatives in attendance will glady furnish literature and answer questions about these and other Ciba products.

Davis & Geck, Inc. **Booth No. 59**
Brooklyn, New York **plus Cinema Room**

Davis & Geck, Inc., manufacturers of sterile surgical sutures will present a program of films on surgery in the Cinema Room adjoining Booth No. 59. These films, selected from the D & G Surgical Film Library, represent twenty years of research and development in the field of visual education as applied to surgical technique. The Library, which contains films on every approved phase of surgery, is constantly expanded to include new and improved operative procedures. Programs of films to be shown will be available at the booth.

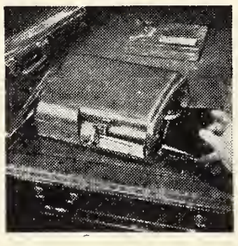
Detroit Creamery Company **Booth No. 78**
Detroit, Michigan



The Detroit Creamery Company has no instruments to demonstrate, nor can they display their dairy products, but physicians are invited to stop at the booth displaying the red and white sign of SEALTEST which symbolizes Quality, through Laboratory Control.

Detroit X-Ray Sales Company **Booth No. 75**
Detroit, Michigan

Dictaphone Corporation **Booth No. 77**
Detroit, Michigan



"The Dictaphone Twins"—world's most popular electronic dictating and transcribing machines—record on reusable non-static cylinders, and for office use are unsurpassed in operating ease and economy.
The sensational new Dictaphone TIME-MASTER, a unique and comfortably portable dictating machine, makes permanent, voice-perfect recordings on mailable, filable plastic Memobelts.

Dietene Company **Booth No. 45**
Minneapolis, Minnesota

Visit the Dietene Company exhibit and discover that really palatable high protein diet supplement—MERITENE. Smell it—taste it—and be convinced.
Also see the personal type diet service that is available, without charge, to physicians. DIETENE Reducing Supplement and the 1,000 calorie Dietene Reducing Diet will also be on display.
Both MERITENE and DIETENE are Council-Accepted.

Doho Chemical Corporation **Booth No. 33**
New York, New York

The makers of Auralgan are featuring, at this meeting, their new sulfa preparation Otosmosan, indicated in the treatment and control of chronic suppurative ears. Also, Mallon, Division of Doho, is introducing the new topical anesthesia, Rectalgan, for relief of pain and itching in hemorrhoids and pruritus. This new therapy enjoys many advantages over the outmoded rectal suppositories and ointments.
Representatives will be happy to explain, in detail, the workings of these medications.

H. G. Fischer & Company **Booth No. 42**
Chicago, Illinois

In the booth of H. G. Fischer & Co. see new units of Fischer X-Ray and Electro-Surgical-Medical apparatus. Let us demonstrate applications of new F.C.C. Type Approved Diathermy units. Your visit will be welcome and appreciated.

C. B. Fleet Company, Inc. **Booth No. 44**
Lynchburg, Virginia

C. B. Fleet Co., Inc., cordially invites you to stop by Booth No. 44 for a short visit with Mr. James A. Reed, the representative who sees you in your office about once a year. Perhaps there is something about Phospho-Soda (Fleet), the pure, stable, aqueous concentrate of the two U.S.P. Sodium Phosphates, you would like to discuss with him.

General Electric X-Ray Corporation **Booth No. 56**
Detroit, Michigan

Gerber Products Company **Booth No. 10**
Fremont, Michigan

Hack Shoe Company **Booth No. 3**
Detroit, Michigan

The busy doctor's substitute for a detail call is a visit to Booth No. 3, where HACK SHOES for men, women and children will be on display as usual.
Many out-of-town physicians and their wives utilize the occasion of the MSMS Detroit meetings to visit the Hack Shoe Company on the Fifth Floor of the Stroh Building for their personal fittings.

Hanovia Chemical & Mfg. Company **Booth No. 26**
Newark, New Jersey

A complete line of ultraviolet quartz lamps for orificial and general body radiation will be on display as well as Wood's black light for diagnostic work, Sollux Radiant Heat Lamps and Safe-T-Aire germicidal lamps for the destruction of air-borne bacteria. Competent and courteous representatives will welcome your visit.

J. F. Hartz Company **Booth No. 43**
Detroit, Michigan

The J. F. Hartz Company appreciates the opportunity of displaying at the Annual Michigan State Medical Society Convention, their line of Laboratory Controlled Pharmaceuticals, as well as the latest in physiotherapy machines, office equipment, surgical and diagnostic instruments.

Hoffmann-La Roche, Inc. **Booth No. 52**
Nutley, New Jersey



Roche will feature THEPHORIN, a different antihistamine which is not likely to cause drowsiness; PRESIDON, the mild new sedative-hypnotic which is not a barbiturate and does not cause "hangover;" and SYRUP SEDULON, a non-narcotic cough remedy especially useful for night cough.

Holland-Rantos Co., Inc. **Booth No. 83**
New York, New York

Representatives will be pleased to show you the new horseshoe shaped diaphragm for cystocele patients, a recent addition to the well-known line of KOROMEX contraceptive specialties. Stop by for a sample of NYLMERATE JELLY for the treatment of trichomoniasis.

G. A. Ingram Company **Booth Nos. 14, 15**
Detroit, Michigan

The G. A. Ingram Company of Detroit will exhibit a complete line of surgical instruments in both stainless steel and chrome, as well as all available electrical appliances. Their representatives will be more than pleased to have you call and obtain information on both new and old items.

A. Kuhlman & Company **Booth No. 72**
Detroit, Michigan

A. Kuhlman & Co. representatives would be pleased to have you call at their booth and inspect the latest design Hamilton wood furniture. They will demonstrate a new short wave machine, approved by the Federal Communications Commission, which features an entirely new method of application. Also on display will be a complete line of surgical instruments.

Lea & Febiger **Booth No. 71**
Philadelphia, Pennsylvania

You will find the Lea & Febiger Exhibit of particular interest because of such outstanding new books and new editions as Ormsby and Montgomery—DISEASES of the SKIN; Gray—ANATOMY of the HUMAN BODY; Frohman—BRIEF PSYCHOTHERAPY; Partipilo—SURGICAL TECHNIC and PRINCIPLES of OPERATIVE SURGERY; Spaeth—PRINCIPLES and PRACTICE of OPHTHALMIC SURGERY; Krimsky—BINOCULAR IMBALANCE; Goldberger—UNIPOLAR LEAD ELECTROCARDIOGRAPHY; Krfaines—THERAPY of the NEUROSES and PSYCHOSES; Burch and Reaser—PRIMER of CARDIOLOGY and many other books of practical help and guidance.

Lederle Laboratories Division **Booth No. 58**
New York, New York

You are cordially invited to visit our exhibit in Booth No. 58, where you will find representatives who are prepared to give you the latest information on Lederle products.

Liebel-Flarsheim Company **Booth No. 8**
Cincinnati, Ohio

The Liebel-Flarsheim Company cordially invites you to stop at Booth No. 8 for examination and demonstration of their latest model diathermy and Bovie electrosurgical equipment. Capable representatives will be on hand at all times to answer your questions about physical therapy and electrosurgical apparatus. We hope you will stop by so that we may become acquainted.

Eli Lilly & Company **Booth No. 73**
Indianapolis, Indiana

Featured at the Lilly exhibit will be new therapeutic developments. Many Lilly products are to be on display; representative literature will be available. Lilly medical service representatives are to be in attendance to aid visiting physicians in every way possible.

J. B. Lippincott Company **Booth No. 1**
Philadelphia, Pennsylvania

J. B. Lippincott Company presents an interesting and active exhibit of professional publishing. With the

"pulse of practice" centering in an advisory editorial board of active clinicians who constantly review the field, current and coming trends in medicine and surgery are known continually. On the studied recommendations of these medical leaders, Lippincott Selected Professional Books are undertaken. It is upon their knowledge, too, of the outstanding work being done in general practice, as well as the specialties, that men making a very real contribution to medical progress are chosen to author the Lippincott books.

M & R Dietetic Laboratories, Inc. **Booth No. 46**
Columbus, Ohio

M & R Dietetic Laboratories, Inc., Booth No. 46, will display Similac, a food for infants deprived of human milk, either partially or entirely. Messrs. F. H. Behncke, L. A. MacDonald, R. L. Wilson, and D. O. Cox will appreciate the opportunity to discuss the merits and suggested application for both the normal and special feeding cases.

Maico Detroit Company **Booth No. 70**
Detroit, Michigan

Our display will consist of hearing aids and audiometers. The new type hearing aid is a small all-in-one instrument that is capable of amplifying the faintest sound 240,000 times.
The new type Maico audiometer makes it possible for the first time to balance hearing so as to assist the doctor in a correct diagnosis of different type impairments.

Mead Johnson & Company **Booth Nos. 28, 29**
Evansville, Indiana

Amigen and Protolysate will be on display at the Mead Johnson Exhibit at your Michigan State Medical Society Meeting. Mead Johnson has pioneered the amino acid field commercially; the products have been described in more than one hundred and forty articles in the medical literature; this year they are available. Trained representatives will be at the Mead Exhibit to discuss details of the new amino acid products. Shown also will be Dextri-Maltose, Pablum Pabena, Oleum Percomorphum and the other Mead Products used in Infant Nutrition. Protenum, a new high-protein product, will be displayed. Also Lonalac for low-sodium diets.

Medical Arts Surgical Supply Company **Booth No. 64**
Grand Rapids, Michigan

The Medical Arts Surgical Supply Company of Grand Rapids will occupy space Number 64 where they will display the latest diagnostic medical equipment such as Beck-Lee electrocardiograms, Liebel-Flarsheim Physio Therapy units and Hamilton medical furniture.

They will be represented by George Klaver, Herb Jacobson, Marshall Koak, Henton Jones, Joe DeBoer, and Jack Corrigan, who invite you to stop in.

Medical Film Guild **Booth No. 5**
New York, New York

Medical Film Guild, through *Medical Films That Teach* presents a refresher course in fundamental medical problems. Each film subject is produced in the manner of a textbook, profusely illustrated, offering information comparable to that found in postgraduate courses as presented at our leading medical schools.
These films review such subjects as Occupational Health Problems, Management of the Failing Heart, Hypothyroidism, Arterial Blood Pressure, The Major Neuralgias, A Clinic on Deafness, Cervicitis, Parkinson's Disease, Otitis Media in Pediatrics, Mastoiditis, Sinusitis, Trichomoniasis and Moniliasis, and many others.
These films are available at no charge to intern groups, hospital staff conferences, limited nurses' groups, and to general medical meetings. This includes projection service at no charge and is arranged through grants for postgraduate instruction.

Medical Protective Company **Booth No. 32**
Fort Wayne, Indiana

We specialize. Ask The Medical Protective Company's representatives to explain how their Company meets the exacting requirements of adequate liability protection, which are peculiar to the Professional Liability field. Their Company has specialized in providing protection for professional men since 1899.

Merck & Company, Inc. **Booth No. 21**
Rahway, New Jersey

Merck presents Neo-Antergan, a new effective antithistaminic agent for symptomatic relief in the oral treatment of certain allergic states including: hay fever, vasomotor rhinitis, urticaria, angioneurotic edema, and allergic drug reactions including those due to penicillin and streptomycin.
Register for a complimentary professional sample of Neo-Antergan.

Wm. S. Merrell Company **Booth No. 24**
Cincinnati, Ohio



Mercodol, the new antitussive syrup containing the better cough-controlling narcotic, Mercodinone, will be featured by Merrell. Mercodinone, a better antitussive agent than either heroin or codeine, is notably free from the undesirable side effects of the older drugs. Mercodol also contains the bronchodilator, Nethamine, and the saline-expectorant sodium citrate.

Michigan Medical Service **Booth No. 6**
Detroit, Michigan

Largest voluntary prepayment medical-surgical plan in the United States. Charts of progress for past year and from inception to date: (a) Assets and Liabilities; (b) Percentage income paid for administrative costs; (c) Paid Doctors for services rendered; (d) Number services rendered; (e) Incidence of service per year for 1,000 subscribers; (f) Cost per case and cases per 1,000 subscribers; (g) Growth in subscribers and services rendered; (h) Number of cases—Veterans program; (i) Advertising program.

C. V. Mosby Company **Booth No. 47**
St. Louis, Missouri

New and recent releases to be displayed at Booth No. 81 by the C. V. Mosby Company will include Crossen "Operative Gynecology," Ackerman-Regato "Cancer," Watson "Hernia," Clendening-Hashinger "Methods of Diagnosis," Pottenger "Tuberculosis," Johnstone "Occupational Medicine and Industrial Hygiene," Top "Communicable Diseases," Jeans-Marriott "Infant Nutrition," Eve "Handbook of Fractures," McCormick "Pathology of Labor, the Puerperium, and the Newborn," Treiger "Atlas of Cardiovascular Diseases," and Goar "Synopsis of Ophthalmology," Shands "Handbook of Orthopedic Surgery," Dunbar "Synopsis of Psychosomatic Diagnosis and Treatment" and Wiener "Skin Manifestations of Internal Disorders." Your examination of any of these, as well as the many other titles to be shown, is cordially invited.

Wm. R. Niedelson Company **Booth No. 51**
Detroit, Michigan

Still the leader of the basal metabolism testers, the *Jones "Motor-Basal"* will be shown, as will the first successful direct-recording electrocardiograph, the *"Cardiotron."* Showing for the first time, the new "Profex" Examining Table Model X-Ray for the general practitioner will be on display. This is an ideal unit for the limited space problem.

Ortho Pharmaceutical Corporation **Booth No. 37**
Raritan, New Jersey

Ortho cordially invites you to Booth 37 where their well known gynecic pharmaceuticals, including Ortho-Gynol and Ortho-Creme will be exhibited. Featured will be NIDOXITAL, for nausea and vomiting of pregnancy, and DIENESTROL CREAM, a topical estrogenic cream for vaginal application in senile and atrophic vaginitis.

Parke, Davis & Company **Booth Nos. 66, 67**
Detroit, Michigan

Members of the Medical Service Staff of Parke, Davis & Company will be available at Booths No. 66 and No. 67 for consultation and discussion relating to regular products classified in our Pharmaceutical, Biologic, and Medicinal Lists. Unusual Specialties of recent development—Benadryl, Etamon Chloride, Oxycel, Thrombin Topical, Influenza Virus Vaccine, Antibiotics, Hypnotics, Amino Acids, and various Biologics will be featured in the Parke, Davis exhibit. You are cordially invited to call at the exhibit with the assurance that your interest will be appreciated.

Pelton & Crane Company **Booth No. 65**
Detroit, Michigan

The Pelton & Crane Company will exhibit Autoclaves, Instruments Sterilizers, and Lights. Exhibit will be in charge of Mr. C. K. Vaughan.

Pet Milk Company **Booth No. 36**
St. Louis, Missouri

A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Philip Morris & Company, Ltd., Inc. **Booth No. 76**
New York, New York

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Picker X-Ray Corporation **Booth No. 82**
New York, New York

The Picker X-Ray Corporation will display the new Weisman Gynograph. This instrument is of the utmost versatility in female sterility procedures. It provides automatic means for the accomplishment of three standard techniques: Carbon dioxide insufflation, Hysterosalpingography and Combined pneumoperitoneum and pelvic viscerography.

Pitman-Moore Company **Booth No. 30**
Indianapolis, Indiana

The Pitman-Moore display will feature a number of that company's recent research developments, including the recently Council Accepted Rabies Vaccine, Ultraviolet-Irradiation Killed, and Magmoid Sulfadiazine. In addition to medical service representatives from the Michigan area, home-office personnel will be in attendance to answer questions concerning recent scientific trends.

Procter & Gamble Company **Booth No. 25**
Cincinnati, Ohio

In Booth No. 25 the Procter & Gamble Company offers the first four of a series of time-saving leaflet pads for doctors. These are entitled, "Instructions for Routine Care of Acne," "Instructions for Bathing a Patient in Bed," "Instructions for Bathing your Baby," and "The Hygiene of Pregnancy."

Professional Management **Booth No. 79**
Battle Creek, Michigan



Professional Management—"A Michigan Institution with a National Reputation" will be on hand, as usual, with members of the firm available, not only to its hundreds of clients, but to all members of the MSMS for consultation regarding Office Records—Partnership Arrangements—Taxes—Fees and The Business Side of Medical Practice in General.

Radium Emanation Corporation **Booth No. 53**
New York, New York

The Radium Emanation Corporation invites you to Booth No. 53 where you will see our wide variety of instruments and applicators used in modern Radium Therapy, including permanent and removable LEAK-PROOF radon seeds. A representative will be available to explain this equipment and its usage.

Randolph Surgical Supply Company **Booth No. 69**
Detroit, Michigan

Randolph Surgical Supply Company will present some fine new equipment, with many new and outstanding time-saving features. Included in this showing will be the very latest in many new diagnostic instruments. On hand to greet our friends will be Cliff Randolph, Arthur Rankin, Fred Greenhut and Myron Ripp.

W. B. Saunders Company **Booth No. 2**
Philadelphia, Pennsylvania

W. B. Saunders Company will exhibit their full line of medical books including Hyman's "Integrated Practice of Medicine," Bockus' "Gastro-enterology," Kinsey's "Sexual Behavior in the Human Male," Sollmann's "Pharmacology," Beckman's "Treatment," Todd & Sanford's "Clinical Diagnosis by Laboratory Methods," Christopher's "Minor Surgery," Cutting's "Clinical Therapeutics," Dowling's "Acute Bacterial Diseases," Noyes' "Clinical Psychiatry," Brams' "Treatment of Heart Disease," A.M.A. Interns Manual, Thorner's "Psychiatry in General Practice," Willius & Dry's "History of Heart and Circulation," Bastedo's "Pharmacology, Therapeutics and Prescription Writing," Wechsler's "Clinical Neurology," and many others.

Schering Corporation **Booth No. 7**
Bloomfield, New Jersey

Among the new pharmaceutical and hormone preparations developed in the Schering research laboratories, MICROPELLETS PROGYNON will be featured. This new potent form of the female sex hormone, alpha estradiol, provides maximum results at minimum cost to the patient. COMBISUL and COMBISUL LIQUID, the triple sulfonamide combinations which eliminate the dangers of sulfonamide renal damage will also be presented. Other new developments will highlight the exhibit. Schering Professional Service Representatives will be present to welcome you and will be happy to answer your inquiries concerning Schering's new products as well as their other hormone, x-ray diagnostic, chemotherapeutic, and pharmaceutical specialties.

G. D. Searle & Company **Booth No. 40**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Hydryllin, the new antihistaminic, as well as such time-proven products as Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine and Pavatrine with Phenobarbital.

Sharp & Dohme, Inc. **Booth No. 17**
Philadelphia, Pennsylvania

Sharp & Dohme extends a cordial welcome to all visitors at Booth No. 17. Items on exhibit include a new dosage form of "Delvinal" Sodium Vinbarbital for the production of obstetric amnesia and analgesia. New antibiotic preparations including Tyrothricin along with "Sulfathalidine" and "Sulfasuxidine," intestinal bacteriostatic agents, are also being featured.

Smith, Kline & French Laboratories **Booth No. 55**
Philadelphia, Pennsylvania

DEXEDRINE SULFATE TABLETS—Dexedrine Sulfate, a notable central nervous stimulant, produces a sustained sense of well-being characteristically free from distracting elation, irritability and inward "nervous tension." This selective action makes it especially valuable whenever accessibility and recreation of interest are desired.

Spencer Incorporated **Booth No. 20**
New Haven, Connecticut

You are cordially invited to visit our exhibit showing individually designed supports for abdomen, back and breasts. Among the supports featured will be the Spencerflex, an unusually comfortable and flexible support for men, especially suitable for postoperative wear. The Spencer Breast Form, designed to restore normal figure lines for patients who have undergone mastectomy, will also be shown.

E. R. Squibb & Sons **Booth No. 74**
New York, New York

Featuring Crysticillin (procaine penicillin G for aqueous injection) and other antibiotic agents.

VanPelt and Brown, Inc. **Booth No. 19**
Richmond, Virginia

Of special interest is Vifoliron, the new and effective blood builder containing ferrous gluconate, ferrous sulfate, liver concentrate, folic acid, and supplementary vitamins.

Barbidonna, sedative and spasmolytic preparation, is also being featured. This preparation is now available both in tablet and elixir forms. For common respiratory disorders Bellaspro and Tussadine have seen wide acceptance.

Inquiries are cordially invited concerning these and other ethical pharmaceuticals of VanPelt and Brown.

Westinghouse Electric Corporation **Booth No. 80**
Pittsburgh, Pennsylvania

Westinghouse will feature the RX x-ray unit. This low-cost single tube x-ray unit is designed to provide the practitioner with the four essential facilities for x-ray work in his office: it permits the doctor to do either prone fluoroscopy, erect fluoroscopy, prone bucky radiography and erect bucky radiography. The table is exceptionally flexible and compact and can be converted to the above four techniques by merely tilting the table to any position desired.

White Laboratories **Booth No. 57**
Newark, New Jersey

White's Dienestrol Tablets (Council-Accepted), a new orally effective synthetic estrogen, is featured. Complete information and literature are available regarding the advantages of Dienestrol's high biologic activity, excellent patient-tolerance and economy.

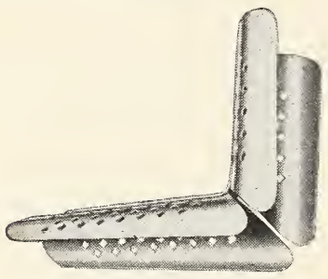
Other products of White Laboratories are on display and White's Medical Service Representatives in attendance will be pleased to supply any further information requested.

Winthrop-Stearns, Inc. **Booth No. 27**
New York, New York

WINTHROP-STEARNS

You are cordially invited to visit the Winthrop-Stearns Booth No. 27 where representatives will be on hand to discuss the latest introductions of this firm. Featured will be Isuprel hydrochloride, the new potent bronchodilator which, for the first time makes anti-asthmatic therapy possible by the sublingual route as well as by inhalation.

Zimmer Manufacturing Company **Booth No. 4**
Warsaw, Indiana



Mr. C. A. Fisher, Zimmer factory representative, will exhibit a complete line of fracture equipment in Booth Number 4.

New items on display for your approval will be the BISHOP LOW SPEED OSCILLATING ATTACHMENT for your LUCK BONE SAW, a new OSCILLATING ELECTRIC CAST SAW, a complete new set of MYERDING CHISELS—GOUGES—OSTEOTOMES, MOREIRA STUD-BOLT, ADJUSTABLE BONE CLAMPS, INTRAMEDULLARY PINS and INSTRUMENTS, THREADED WIRES and PINS, STAPLE SET, ADJUSTABLE INTERTROCHANTERIC PLATE and NAIL, RUBBER CUSHION WALKING HEELS, and a new WIRE AND PIN CUTTER.

THE SPECIALTY BOARDS

(Continued from Page 745)

have now been raised to that level for new applicants.

To date, the American Board of Surgery has granted its certificate to 1,156 in its Founders Group, and 2,120 by examination. In selecting those considered eligible for examination, less than half of those who write to the board are encouraged to submit applications. When applications are filed, about 20 per cent are rejected as not meeting the board's requirements. Of those admitted to the board's examinations, about 25 per cent will fail on their first attempt to receive passing grades. I only mention these details in support of the statement made early in this paper, that the chief purpose of a specialty board, we believe, should be to certify only those who can meet a high standard of performance in proving their claim to be a specialist in surgery, rather than to encourage a much larger number than the country needs who cannot meet its requirements.

Michigan State Medical Society
Roster 1948

(Special Memberships are indicated as follows: "E" for Emeritus Members; "L" for Life Members; "R" Retired Members; "A" for Associate Members, and "M" for Military Members; all others are Active Members)

Allegan County

Baker, A. G.....Allegan
Brown, Lewis Freeman.....Otsego
Brunson, Eugene T.....Ganges
Burdick, J. G.....Allegan
Chase, Walter E.....Martin
Corkill, C. C.....Douglas
Dickinson, C. A.....Wayland
Hudnutt, Orrin Dean.....Plainwell
Johnson, E. B.....Allegan
Kromer, R. A.....Wayland
Mahan, James E.....Allegan
Medill, W. C.....Plainwell
Miller, K. C.....Saugatuck
Ramseyer, Gladwin E.....Plainwell
Rummell, Robert J.....Fennville
Stuck, Olin H.....Otsego
Ten Pas, Henry W.....Hamilton
Van Der Kolk, Bert.....Hopkins
Vaughan, W. R.....Plainwell
Wiseman, Bertha Chase.....Allegan

Alpena-Alcona-Presque Isle Counties

Arscott, E. F.....Rogers City
Bunting, John W.....Alpena
Burkholder, H. J.....Alpena
Carpenter, Clarence A. (L).....Onaway
Constantine, Aeneas.....Harrisville
Foley, Arthur L.....Rogers City
Foley, E. L.....Alpena
Hier, Edward A.....Alpena
Jackson, W. P.....Rogers City
Kessler, Harold.....Alpena
Lister, George F.....Hillman
Nesbitt, Wm. E.....Alpena
O'Donnell, F. J.....Alpena
Parmenter, E. S.....Alpena
Ramsey, J. A.....Alpena
Spens, James E.....Alpena
Wagoner, Darwin E.....Lincoln
Wienczewski, Theophile.....Alpena

Barry County

Bernard, Prosper G.....Delton
Clarke, Daniel M.....Hastings
Finnie, R. G.....Hastings
Gwinn, A. B.....Hastings
Hankamp, La Mar J.....Delton
Harkness, Robert B.....(L) Hastings
Hoffs, M. A.....Lake Odessa
Keller, Guy C.....(L) Hastings
Lofdahl, Stewart.....Nashville
McIntyre, K. S.....Hastings
Morris, Edgar T.....(L) Nashville
Phelps, Everett L.....Hastings
Slee, Vergil.....Hastings
Wedel, Herbert S.....Hastings

Bay-Arenac-Iosco Counties

Alcorn, Kent.....Bay City
Alcorn, Marshall.....Bay City
Allen, A. D.....Bay City
Asline, J. N.....Essexville
Austin, Justis.....Tawas City
Ballard, W. R.....(E) Bay City
Boulton, A. O.....(E) Gladwin
Brown, G. M.....Bay City
Chapin, Frederick S.....Bay City
Connelly, J. C.....Bay City
Criswell, R. H.....Bay City
Dardas, M. J.....Bay City
DeWaele, Paul L.....Bay City
Dolbee, Malcolm.....Standish
Drummond, Fred.....Kawkawlin
Dumond, V. H.....Bay City
Ely, Nina (L).....Bay City
Fisher, Robert E.....Bay City
Foster, L. Fernald.....Bay City
Freel, John A.....Bay City
Gamble, W. G., Jr.....Bay City
Grosjean, J. C. (L).....Bay City
Gunn, Robert.....Bay City
Haitinger, K. S.....Auburn
Hagelshaw, G. L.....Bay City
Hess, C. L.....Bay City
Heuser, Harold H.....Bay City
Horowitz, S. Franklin.....Bay City
Huckins, E. S.....Bay City
Huckins, Rodger S.....Bay City
Hughes, E. C.....(L) Bay City
Husted, F. Pitkin.....Bay City
Jacoby, A. H.....Bay City
Jens, Otto.....Essexville
Johnson, Orlen J.....Bay City
Jones, Culver.....Bay City
Jones, Jerry M.....(E) Bay City
Keho, John.....(L) Bay City
Kessler, Mana.....Bay City
Kessler, Saba.....Bay City
Knobloch, Howard.....Bay City
Lerner, David.....Au Gres
Loftin, Robert.....Bay City
McDonnell, Walter R.....Pinconning
McEwan, J. H.....Bay City
MacPhail, Joseph.....Bay City
MacRae, L. Douglas.....Bay City
Medvezky, M. J.....Bay City
Miller, Edwin C.....Bay City
Mitton, Orland W.....East Tawas
Moore, George W. (L).....Bay City
Moore, Neal R.....Bay City
Mosier, D. J.....Bay City
Pearson, Stanley M.....Bay City
Reuter, C. W.....Bay City
Scrafford, Royston Earl.....Bay City
Shafer, Harold C.....Bay City
Sherman, R. N.....Bay City
Smith, J. Campbell.....Bay City
Staley, Hugh.....Omer
Stinson, W. S.....Bay City
Stewart, G. C.....Bay City
Tarter, Clyde S.....Bay City
Timreck, Harold A.....Gladwin
Tupper, Virgil L.....(R) Bay City
Urmston, Paul R.....Bay City
Vail, Harry F.....Bay City
Warren, E. C.....(E) Bay City
Wilcox, J. W.....Bay City
Wilson, Thomas G.....Bay City
Wittwer, E. A. (L).....Bay City
Zaremba, Aloysius J.....Bay City
Ziliak, A. L.....Bay City

Berrien County

Allen, Robert C.....St. Joseph
Anderson, Bertha.....St. Joseph
Anderson, H. B.....Watervliet
Belsley, Frank K.....Benton Harbor
Bjork, Harold.....St. Joseph
Bliesmer, A. F.....St. Joseph
Brown, F. W.....Watervliet
Burrell, H. J.....Benton Harbor
Cawthorne, H. J.....Benton Harbor
Conybeare, R. C.....Benton Harbor
Cowdery, K. H.....St. Joseph
Crowell, Richard.....St. Joseph
Dunnington, R. N.....Benton Harbor
Emery, Clayton.....St. Joseph
Faber, Michael.....Benton Harbor
Foucek, B. Charles.....Three Oaks
Friedman, Morris.....New Buffalo
Garrett, Evan L.....Niles
Gillette, Clarence H.....Niles
Green, Robert.....Eau Claire
Gregory, James.....Berrien Center
Hanna, P. G.....St. Joseph
Harper, Ina.....Benton Harbor
Harrison, L. L.....Niles
Hart, Russell.....Niles
Henderson, Fred.....Niles
Henderson, Robert.....Niles
Hershey, Noel J.....Niles
Holt, Robert E., Jr.,.....Niles
Johnson, O. V.....Benton Harbor
Kelsall, H. I.....St. Joseph
King, B. B.....Benton Harbor
King, Frank, Jr.....Benton Harbor
Kling, H. C.....Niles
Kok, Harry.....Benton Harbor
Lawton, Clare V.....Benton Harbor
Leva, John B.....Benton Harbor
Louisell, Charles T.....St. Joseph
Miller, E. A.....Berrien Springs
Mitchell, Carl A.....Benton Harbor
Moore, T. Scott.....Niles
Neville, J. William.....Benton Harbor
Ozeran, C. J.....Benton Harbor
Pritchard, H. M.....Niles
Reagan, Robert E.....Benton Harbor
Rein, Gerald.....Benton Harbor
Rice, F. A.....Niles
Rice, Franklin.....Niles
Richmond, D. M.....St. Joseph
Ruth, J. Griswold.....Benton Harbor
Schairer, William W.....Coloma
Smith, W. A.....Berrien Springs
Sowers, Bouton.....Benton Harbor
Strayer, J. C.....Buchanan
Strick, Marvin H.....Benton Harbor
Thorup, D. W.....Benton Harbor
Tompkins, C. E.....Benton Harbor
Urist, Maurice D.....Benton Harbor
Waterson, Roy S.....Niles
Westervelt, H. O.....Benton Harbor
Winter, Joseph A.....St. Joseph
Yeomans, T. G.....St. Joseph

Branch County

Andrews, Frank A.....Coldwater
Atkinson, A. L.....Quincy
Bailey, J. E.....Coldwater
Beck, Perry C.....Bronson
Bien, W. J.....Coldwater
Culver, Bert W.....Coldwater
Culver, Dean.....Bronson
Fraser, R. J.....Coldwater
Heustis, Albert E.....Coldwater
Leitch, R. M.....Union City
McLain, R. W.....Jackson
Meier, H. J.....Coldwater
Mooi, H. R.....Coldwater
Olmstead, Kenneth L.....Coldwater
Rees, Kendall B.....Coldwater
Rennell, E. J.....Coldwater
Thomas, J. A.....Coldwater
Wade, R. L.....Coldwater
Walton, N. J.....Quincy
Weidner, H. R.....Coldwater

Calhoun County

Albright, Arnold A. (M).....Battle Creek
Alling, Emery E. (M).....New York City
Altman, George L. (M).....New York
Amos, Norman H.....Battle Creek
Barden, Stuart P.....Battle Creek
Baribeau, R. H.....Battle Creek
Becker, H. F.....Battle Creek
Berwald, Herbert T. (M).....Battle Creek
Beuker, Herman.....Marshall
Bodine, Harold R.....Battle Creek
Bonifer, Philip P.....Battle Creek
Brainard, C. W.....Battle Creek
Cameron, J. M. (M).....Battle Creek
Campbell, Alice.....Albion
Campbell, R. J.....Battle Creek
Capron, Manley J.....Battle Creek
Church, Starr K.....(E) Marshall
Chynoweth, W. R.....Battle Creek
Coleman, Floyd B. (M).....Battle Creek
Cooper, J. E.....Battle Creek
Cretsinger, Francis C. (M)....Battle Creek
Curry, Robert K.....Homer
Dickson, A. R.....Battle Creek
Dodge, Warren M., Jr.....Battle Creek
Fairbanks, Stephen.....Albion
Finch, D. L.....Battle Creek
Forsyth, J. F.....Albion
Fraser, R. H.....Battle Creek
Funk, L. D.....Athens
Gething, Joseph W.....Battle Creek
Giddings, A. M.....Battle Creek
Gilfillan, Margery J.....Battle Creek
Gorsline, Clarence S. (L).....Battle Creek
Graubner, F. L.....Marshall
Gregory, Charles F. (M).....Battle Creek
Hansen, E. L.....Battle Creek
Hansen, Harvey C.....Battle Creek
Haughey, Wilfrid.....Battle Creek
Heald, C. W.....Battle Creek
Henderson, Philip.....Albion
Herzer, Henry A.....Albion
Hibbs, Donald K.....Battle Creek
Hills, C. R.....Battle Creek
Hollands, Robert A.....Battle Creek
Holtom, B. G.....Battle Creek
Hoyt, Aura A.....Battle Creek
Hubly, James W.....Battle Creek
Humphrey, Archie E.....Marshall
Humphrey, Arthur A.....Battle Creek
Jeffrey, J. R.....Battle Creek
Jesperson, Lydia (L).....Battle Creek
Jones, H. Aubrey.....Marshall
Jones, Robert R. (M).....Battle Creek
Jones, T. K.....Marshall
Keagle, Leland R.....Battle Creek
Keeler, K. B.....Albion
Kimball, A. S., Jr.....Battle Creek
Kinde, M. R.....Battle Creek
Kingsley, Paul C.....Battle Creek
Knapp, Nettie E.....Battle Creek
Kolvoord, Theodore.....Battle Creek
LaFrance, N. Francis.....Battle Creek
Lam, Francis.....Battle Creek
Levy, Joseph.....Battle Creek
Lewis, W. B.....Battle Creek
Linn, Frank D.....Albion
Lodmell, Elmer A. (M).....Battle Creek
Lowe, Kenneth M.....Battle Creek
Lowe, Stanley T.....Battle Creek
MacGregory, Arch. E. (L)....Battle Creek
Manni, Lawrence C.....Battle Creek
McNair, Lawrence N.....Albion
Meister, F. O.....Battle Creek
Melges, F. J.....Battle Creek
Mercer, C. M.....Battle Creek
Morrison, Donald.....Battle Creek
Moshier, Bertha.....(R) Battle Creek
Mullenmeister, H. F.....Battle Creek
Mustard, Russell.....Battle Creek
Patrick, Gilbert.....Battle Creek
Patterson, Adonis.....Wash., D. C.
Pearson, Donald J.....Battle Creek
Putnam, W. N.....Battle Creek
Robbert, John.....Battle Creek
Robins, Hugh.....Marshall
Rorick, Wilma Weeks.....Battle Creek
Rosenfeld, Joseph E.....Battle Creek
Royer, C. W.....Battle Creek
Rylander, Carl M. (M).....Battle Creek
Satterthwaite, R. W. (M)....Battle Creek
Schelm, George W.....Battle Creek
Schwary, Frank W.....Battle Creek
Selmon, Bertha L. (L).....Battle Creek
Sharp, A. D.....Albion
Shipp, L. P.....Battle Creek
Shellenberger, Herbert M.....Marshall
Sibilsky, A. Clark.....Battle Creek
Simpson, Robert S.....Battle Creek
Slagle, George W.....Battle Creek
Sleight, James D.....Battle Creek
Stadle, Wendell H.....Battle Creek
Stiefel, Richard.....Battle Creek
Strohmenger, Frank J.....Albion
Sullivan, Donel (M).....Battle Creek
Tannenholz, Harold S.....Battle Creek
Taylor, Clifford B.....Albion
Thompson, Fred R.....Battle Creek
Thompson, Ralph M. (M).....Battle Creek
VanderVoort, W. V. (L).....Battle Creek
Verity, Lloyd E.....Battle Creek
Walters, F. R.....Battle Creek
Walters, John F.....Battle Creek
Wencke, Carl G.....Battle Creek
Winslow, Sherwood B.....Battle Creek
Wiseley, Allen N.....(M) Battle Creek
Worgess, Duane R.....Battle Creek
Zindler, George A.....Battle Creek

Cass County

Adams, U. M.....Marcellus
Britton, George T.....Marcellus
Clary, R. I.....Dowagiac
Hickman, John.....Dowagiac
Kelsey, James H.....Cassopolis
Loupee, George E.....Dowagiac
Loupee, S. L.....Dowagiac
Lyman, W. R.....Dowagiac
Newsome, Otis.....Cassopolis
Pierce, Kenneth C.....Dowagiac
Zwergel, E. H.....Cassopolis

Chippewa-Mackinac Counties

Bandy, F. C.....Sault Ste. Marie
Blain, James G.....Sault Ste Marie
Blair, H. M.....Sault Ste Marie
Carr, E. S.....Pickford
Cowan, Donald A.....Sault Ste Marie
Finlayson, D. D.....Sault Ste. Marie
Gilfillan, E. O.....Saut Ste Marie
Goldberg, A. H.....Sault Ste. Marie
Hagele, Marie A.....Sault Ste. Marie
Harrington, H. M.....Sault Ste. Marie
Hamel, Herbert E.....St. Ignace
Howe, D. C.....Sault Ste. Marie
Howe, Gertrude.....Sault Ste. Marie
Mackie, Thomas B.....Sault Ste Marie
McBryde, Lyman M.....Sault Ste. Marie
Mertaugh, W. F.....Sault Ste. Marie
Montgomery, B. T.....Sault Ste. Marie
Rhind, E. S.....Sault Ste Marie
Scott, Dwight F.....Sault Ste Marie
Thompson, T. W.....Sault Ste. Marie
Trapasso, T. G.....Sault Ste. Marie
Wallen, LeRoy J.....Sault Ste. Marie
Willison, C.....(E) Sault Ste. Marie
Yale, I. V.....Sault Ste. Marie

Clinton County

Cook, Bruno.....Westphalia
Elliott, Bruce R.....Ovid
Foo, Charles T.....St. Johns
Frace, Guy H.....St. Johns
Henthorn, A. C.....St. Johns
Ho, Thomas Y.....St. Johns
Luton, F. E.....St. Johns
McWilliams, W. B.....Maple Rapids
Miller, Charles S.....Big Rapids
Russell, Sherwood R.....St. Johns
Stoller, Paul F.....St. Johns
Wahl, George Edward.....St. Johns

Delta-Schoolcraft Counties

Benson, G. W.....Escanaba
Bernier, A. Barrso.....Nahma
Boyce, D. H.....Escanaba
Brenner, Ervin J.....Manistique
Carlton, A. J.....Escanaba
Chenoweth, Nancy R.....(E) Peterborough Ontario, Canada
Clausen, Claire H.....Dearborn
Defnet, Harry John.....Escanaba
Dehlin, James R.....Gladstone
Diamond, J. A.....Gladstone
Frenn, N. J.....Bark River
Fyvie, James.....Manistique
Groos, Harold Quinten.....Escanaba
Groos, Louis P.....Escanaba
Harrison, William C.....Escanaba
Hult, Otto S.....Gladstone
Kee, Charles E.....Gladstone
Lemire, Donald F.....Escanaba
Lemire, Wm. A.....Escanaba
Lindquist, N. L.....Escanaba
McInerney, Thomas A.....Escanaba
Miller, Albert H.....Gladstone
Moll, G. W.....Escanaba
Ryde, Robert E.....Gladstone
Shaw, George A.....Manistique
Walch, J. J.....Escanaba
Wehner, Merle E.....Manistique

Dickinson-Iron Counties

Addison, E. R.....Crystal Falls
Alexander, W. H.....Iron Mountain
Boyce, George H.....Iron Mountain
Browning, James L.....Iron Mountain
Cooper, C. A.....Stambaugh
Fiedling, Wm.....Norway
Hayes, R. E.....Sagola
Hayes, Willard N.....Norway
Huron, W. H.....Iron Mountain
Irvine, L. E.....Iron River
Kofmehl, Wm. J.....Stambaugh
McEachran, Hugh D.....Iron Mountain
Palm, E. Theodore.....Crystal Falls
Retallack, R. C.....Iron River
Smith, Donald R.....Iron Mountain
Steinke, Charles G.....Iron Mountain

Eaton County

Arner, Fred Levi....Bellevue
Brown, B. Philip....Charlotte
Carothers, Daniel J....Charlotte
Hannah, H. W....Charlotte
Harrod, Gordon....Grand Ledge
Huber, Chas. D. (L)....Charlotte
Imthun, Edgar F....Grand Ledge
Meinke, Albert....Eaton Rapids
Myers, Albert W....Potterville
Sevener, Lester G....Charlotte
Stucky, Geo....Charlotte
Van Ark, Bert....Eaton Rapids
Van Ark, Herman....Eaton Rapids
Whitlock, S. C....Dimondale
Willits, C. O....Charlotte

Genesee County

Adams, Burnell....Flint
Adams, Chester....Grand Blanc
Anderson, Harley H....Mt. Morris
Andrews, N. A. C....Flushing
Anthony, Geo. E....Flint
Backus, Glenn R....Flint
Baird, W. C....Flint
Bald, Frederick W....Flint
Barbour, Fleming A....Flint
Baske, Franklin....Flint
Bateman, L. G....Flint
Benson, J. C., Sr....Flint
Benson, John C., Jr....Flint
Bernstein, Eli N....Flint
Beyer, Damon P....Clio
Beyer, George D....Clio
Biggar, H. R....Flint
Bishop, D. L....Flint
Blakeley, A. C....Flint
Bogart, Leon M....Flint
Boles, William P....Flint
Bonathan, Alvin T....Flint
Bradley, Robert....Flint
Brain, R. Gordon....Flint
Branch, Hira E....Flint
Brasie, Donald R....Flint
Briggs, Guy D....Flint
Bruce, Wm. W....Swartz Creek
Buchanan, W. Fremont....Fenton
Burkett, L. V....Flint
Burnell, Max....Flint
Caster, E. Wilbur....Huntington Woods
Chambers, Myrton S....Flint
Chandler, M. E....(L) Flint
Charters, John H....(E) Flint
Clark, Clifford P....Flint
Colwell, C. W....Flint
Connell, J. T....Flint
Conover, G. V....Flint
Conover, McClellan....Flint
Conover, T. S....Flint
Cook, Henry....Flint
Covert, F. L....Gaines
Craig, William G....Flint
Credille, B. A....Flint
Curry, George....Flint
Curtin, J. H....Flint
Cutler, G. Campbell....Flint
David, T. George....Flint
Del Zingro, N....Davison
Denholm, Nan H....Flint
Dickstein, Bernard....Flint
Dimond, E. G....Flint
Dodds, F. E....Flint
Eichhorn, Ernest....Flint
Eickhorst, Thomas N....Flint
Elliott, H. B....Flint
Evers, J. W....Flint
Ettinger, Ralph D....Fenton
Farhat, M. M....Flint
Fee, Manson G....Flint
Finkelstein, T....Flint
Flynn, S. T....Flint
Foley, S. I....Flint
Fuller, H. T....Mt. Morris
Gelenger, Stephen M....Flint
Gleason, N. Arthur....Flint
Golden, H. Maxwell....Flint
Goodfellow, B. A....Flint
Gorne, S. S....Flint
Griffin, Ernest P., Jr....Flint
Grover, H. F....Flint
Guile, Earl B....(L) Flint
Guile, G. S....Flint
Gundry, G. L....Grand Blanc
Gutow, I....Flint
Gutow, J. J....Flint
Hague, R. F....Flint
Halligan, Raymond S....Flint
Hamady, Ruth....Flint
Hamilton, A. J....Flint
Harper, Alex W....(L) Flint
Harper, Homer....Flint
Hawkins, James E....Flint
Hays, George A....Flint
Hiscock, H. H....Flint
Hooper, Kendall....Flint
Houston, James....(L) Swartz Creek
Hubbard, Wm. B....Flint
Hufton, Wilfred L....Flint
Jermstad, Robert J....Flint
Johnson, Arthur H....Flint
Johnson, Frank D....Flint
Jones, Lafon....Flint
Judd, Alvin....Flint
Kaleta, Edward....Flint
Kaufman, Lewis D....Flint
Knapp, M. S....(R) Fenton
Knapp, Wm. D....Flint
Kretchmar, A. H....Flint
Kurtz, J. J....Flint
Lambert, L. A....Flint
Leach, J. L....Flint
Limbach, David R....Flint
Livesay, Jackson E....Flint
Logan, G. W....(L) Flushing
MacDuff, R. B....Flint
MacGregor, D. M....Flint
Macksood, Joseph....Flint
Marsh, H. L....Flint
McArthur, A....Flint
McGarry, R. A....Flint
McKenna, O. W....(E) Flint
McLeod, K. W. A....Flint
Miller, Bryce....Flushing
Miller, Loren Eugene....Flint
Miltich, Anthony J....Flint
Moore, Kenneth B....Flint
Moore, Wesley P....Flint
Morrish, Ray S....Flint
Morrison, William H....Goodrich
Morrissey, V. H....Flint
Mosier, Edward C....Otisville
Odle, Ira....Flint
O'Neil, C. H....(R) Deckerville
Orr, J. Walter....Flint
Phillips, R. L....Flint
Pfeifer, A. C....Mt. Morris
Pratz, O. C....Flint
Preston, Otto....Flint
Randall, H. E....(E) Flint
Rawlings, J. Mott....Flint
Reeder, Frank E....Flint
Reichard, Orill....Flint
Reid, Wells C....Goodrich
Richeson, V....Flint
Rieth, George F....Flint
Roberts, Floyd A....Flint
Rulney, Max....Flint
Rundles, Walter Z....Flint
Rynearson, W. J....Fenton
Sandy, K. R....Flint
Scavarda, Charles J....Flint
Schiff, Benton A....Flint
Schreiber, E. Oskar....Flint
Scott, R. D....Flint
Searles, Karl F....Flint
Shantz, L. O....Flint
Sheeran, Daniel H....Flint
Shipman, Charles W....Flint
Sirna, Anthony R....Flint
Sleeman, Blythe R....Linden
Smith, D. C....Flint
Smith, E. C....Flint
Smith, Maurice J....Flint
Sniderman, Benjamin....Flint
Snyder, Charles E....Swartz Creek
Sorkin, Morris L....Flint
Sorkin, S. S....Flint
Sparks, Harvey D....Flint
Steffe, Ralph S....Flint
Steinman, Floyd H....Flint
Stephenson, Robert A....Flint
Stevenson, W. W....Flint
Streat, R. W....Flint
Stroup, C. K....Flint
Sutherland, James K....Flint
Sutton, George....Flint
Sutton, M. R....Flint
Thompson, Alvin....Flint
Tofteland, Elmer H....Flint
Treat, D. L....(L) Flint
Trumble, G. W....Flint
Turner, Merald G....Flint
Van Gorder, George....Davison
Van Harn, R. S....Flint
Vary, Edwin P....Flint
Walcott, C. G....Fenton
Ward, Nell....Flint
Ware, Frank A....Flint
Wark, D. R....Flint
Wentworth, John E....Flint
Werness, Inga W....Flint
Westcott, George W....Goodrich
White, Carl H....Fenton
White, Herbert....Flint
Williams, W. S....Flint
Willoughby, G. L....Flint
Willoughby, L. L....(L) Flint
Wills, T. N....Flint
Winchester, Walter H....(L) Flint
Woughter, Harold W....Flint
Wright, D. W....Flint
Wyman, J. S....Flint

Gogebic County

Albert, S. G....Ironwood
Anderson, Charles E....Anvil
Davidson, Donald L....Bessmer
Eisele, D. C....Ironwood
Franck, J. R....Wakefield
Gertz, M. A....Ironwood
Gingrich, Wayne A....Ironwood
Gorrilla, A. C....Ironwood
Lieberthal, M. J....Ironwood
Lieberthal, Paul....Ironwood
Lojacono, Salvatore....Ironwood
Maccani, Wm. L....Ironwood
Nezworski, H. T....Ironwood
O'Brien, A. J....Ironwood
Pinkerton, H. A....Ironwood
Stevens, Chas. E....Ironwood
Tressel, H. A....Wakefield
Urquhart, C. C....Ironwood
Wacek, W. H....Ironwood

Grand Traverse-Leelanau-Benzie Counties

Beall, John G....Traverse City
Berghorst, John....Traverse City
Bolan, Ellis J....Suttons Bay
Brownson, Jay J....Kingsley
Brownson, Kneale M....Traverse City
Bushong, B. B....Traverse City
Cannon, Robert....Traverse City
Ellis, Claude I....Suttons Bay
Evseef, George S....Traverse City
Gauntlett, J. W....(L) Traverse City
Goodrich, Dwight....Traverse City
Haberlein, Charles R....Traverse City
Hall, James W....Traverse City
Hamilton, Earl E....Traverse City
Huene, Nevin....Traverse City
Huston, Russell R....Elk Rapids
Wm. T. Hyslop....Traverse City
Jerome, Jerome T....Traverse City
Kyselka, H. B....Traverse City
Lemen, Chas. E....Traverse City
Lentz, R. J....Traverse City
Lossman, Robert T....Detroit
Manwaring, Thomas....Traverse City
Meng, Ralph H....Traverse City
Mumby, Clinton J....Traverse City

Nickels, M. M.....Traverse City
Osterhagen, H. F.....Traverse City
Osterlin, Mark.....Traverse City
Pike, Donald.....Traverse City
Power, Frank H.....Traverse City
Salon, Dayton D.....Traverse City
Sheets, R. Philip.....Traverse City
Sladek, E. F.....Traverse City
Stone, Fordyce H.....Beulah
Swartz, F. G.....Traverse City
Thirlby, E. L.....Traverse City
Trautman, Frederick B.....Frankfort
Way, Lewis R.....Traverse City
Weitz, Harry.....Traverse City
Whitehouse, John D.....Traverse City
Wilcox, Paul H.....Traverse City
Willoughby, Frances L.....Washington 25, D. C.
Zielke, I. H.....Traverse City
Zimmerman, J. G.....Traverse City

Gratiot-Isabella-Clare Counties

Aldrich, Alfred L.....Ithaca
Barstow, D. K.....St. Louis
Barstow, Wm. E.....St. Louis
Becker, Myron G.....Edmore
Budge, M. J.....Ithaca
Burch, L. J.....(E) Mt. Pleasant
Burt, C. E.....Ithaca
Davis, L. L.....Mt. Pleasant
Drake, Wilkie M.....Breckenridge
DuBois, C. F.....Alma
Graham, B. J.....Alma
Gray, Thomas J.....Mt. Pleasant
Hall, B. C.....(E) Pompeii
Hammerberg, Kuno.....Clare
Harrigan, Wm. L.....Mt. Pleasant
Hersee, Wm. E.....Mt. Pleasant
Hobbs, A. D.....St. Louis
Hyslop, Leland F.....Mt. Pleasant
Kilborn, H. F.....Ithaca
McArthur, Stewart C.....Clare
Miller, S. W.....Alma
Oldham, E. S.....Breckenridge
Putzig, Louis M.....Blanchard
Rondot, E. F.....Mt. Pleasant
Rottschafer, J. L.....Alma
Strange, Russell H.....Mt. Pleasant
Waggoner, R. L.....St. Louis
Wilcox, R. A.....Alma
Wilson, Earl C.....Harrison
Wolfe, Kenneth P.....Alma
Wood, Cornelius B.....Mt. Pleasant

Hillsdale County

Bates, Morton P.....Hillsdale
Day, Luther W.....Jonesville
Douglas, E. W.....Hillsdale
Green, B. F.....Hillsdale
Hanke, Geo. R.....Ransom
Hodge, C. L.....Reading
Hughes, Henry F.....(L) Hillsdale
Kline, Fred D.....Litchfield
MacNeal, John A.....Hillsdale
Martindale, E. A.....(L) Hillsdale
Mattson, H. F.....Hillsdale
McFarland, O. G.....North Adams
Miller, Harry C.....(L) Hillsdale
Peterson, Carl A.....Hillsdale
Sawyer, Walter W.....Hillsdale
Strom, A. W.....Hillsdale
Trapp, Donald.....Hillsdale
Wiggings. I. W.....Jonesville

Houghton County

Aldrich, A. B.....Houghton
Aldrich, Addison D.....Houghton
Aldrich, Leonard C.....Hancock
Bourland, Phillip D.....(L) Calumet
Brewington, George F.....(E) Mohawk
Burke, John J.....Hubbell
Conrad, George B.....Houghton
Gregg, W. T. S.....(E) Calumet
Hillmer, Raymond E.....Painesdale
Hosking, Frederick S.....Laurium
Janis, A. J.....Houghton
King, Wm. T.....Ahmeek
Kirton, Job R. W.....Calumet
Kolb, F. E.....Calumet
LaBine, Alfred.....Houghton
Levin, Simon.....Houghton
MacQueen, Donald K.....(E) Laurium
Manthei, W. A.....Lake Linden
Murphy, Percy J.....Ahmeek
Quick, James B.....(L) Laurium
Roberts, Melvin D.....Hancock
Roche, A. C.....Calumet
Roche, Andrew M.....Larium
Sarvela, H. L.....Hancock
Scott, Benton V. D.....Chassell
Sloan, P. S.....Houghton
Smith, Charles R.....Hancock
Stahr, H. S.....Modesta, Calif.
Stern, Isadore D.....Houghton
Whitmore, R. C.....Hancock
Wickliffe, John T. P.....Calumet
Winkler, Henry J.....L'Anse
Wood, Neal N.....Calumet

Huron County

Dixon, R. C.....Pigeon
Henderson, J. Bates.....Sebewaing
Herrington, Charles I.....Bad Axe
Herrington, Willet J.....Bad Axe
Holdship, Wm. B.....Ubly
Monroe, Duncan J.....(L) Elkton
Morden, Charles B.....Bad Axe
Oakes, C. W.....Harbor Beach
Ritsema, John.....Sebewaing
Scheurer, Clare A.....Pigeon
Sorensen, Maurice G.....Kinde
Staryk, Steven E.....Kinde
Steinhardt, Edward E.....Elkton
Thumme, Harrison F.....Sebewaing
Turner, Phillip R.....Harbor Beach

Ingham County

Alexander, Reuben G.....Lansing
Altland, J. K.....Lansing
Bartholomew, Henry S.....(R) Lansing
Bauer, Theodore I.....Lansing
Bellinger, E. G.....Lansing
Bradford, C. W.....Lansing
Breakey, Robert S.....Lansing
Briede, Paul C.....Lansing
Burhans, Robert.....Lansing
Cameron, W. J.....Lansing
Carr, E. I.....Lansing
Clarke, Emilie Arnold.....Lansing
Cope, H. E.....Lansing
Corneliuson, Goldie B.....Lansing
Cross, Frank S.....Lansing
DeKleine, William .....Lansing
Doyle, C. P.....(E) Lansing
Drolett, Lawrence.....Lansing
Dunn, F. C.....(L) Lansing
Ellis, Bertha.....East Lansing
Ellis, C. W.....Lansing
Feeney, Kenneth J.....Lansing
Folkers, Leonard M.....East Lansing
French, Horace L.....Lansing
Gould, Marian Iddings.....Lansing
Harrison, W. H.....Lansing
Hart, L. C.....Lansing
Heckert, Frank B.....Lansing
Heckert, J. K.....Lansing
Hendren, Owen.....Lansing
Himmelberger, R. J.....Lansing
Huggett, Clare C.....Lansing
Hurth, M. S.....Lansing
Jacob, S. Sprigg.....East Lansing
Johnson, K. H.....Lansing
Kahn, David.....Lansing
Kalmbach, R. E.....Lansing
Kenyon, Fanny H.....Lansing
Lanting, Helen E.....East Lansing
Lanting, Roelof.....Lansing
Markuson, Kenneth E.....Lansing
McConnell, E. G.....(R) Lansing
McCorvie, C. Ray.....East Lansing
McCoy, Earl M.....Grand Ledge
McElmurry, Leland R.....Lansing
McNamara, William E.....Lansing
Miller, H. A.....Lansing
Mitchell, A. B.....Lansing
Ochsner, P. J.....Lansing
O'Sullivan, Gertrude.....(E) Mason
Pinkham, R. A.....Lansing
Place, Edwin H.....Lansing
Rector, Frank L.....Ann Arbor
Rozan, Milton.....Lansing
Russell, Claude V.....(R) Lansing
Sander, John F.....Lansing
Sanford, Thomas M.....(E) Lansing
Scheidt, R. Rudolph.....Lansing
Seger, Fred L.....(L) Lansing
Shaw, Milton.....Lansing
Sichler, Harper G.....Lansing
Snyder, Ruth E.....Lansing
Stanka, Andrew G.....Grand Ledge
Steiner, A. A.....Lansing
Steiner, S. D.....Lansing
Stiles, Frank.....Lansing
Trimby, Robert H.....Lansing
Troost, F. L.....Holt
Vander Zalm, T. P.....Lansing
Wellman, John M.....Lansing
Wilensky, Thomas.....Lansing
Willson, Howard S.....Lansing
Wilson, Harry A.....Lansing

Ionia-Montcalm Counties

Anderson, Donald H.....Portland
Bird, Wm. L.....Greenville
Bracey, L. E.....Sheridan
Bunce, E. P.....Trufant
Bunce, Leo.....Trufant
Dunkin, Lloyd S.....Greenville
Fleming, J. C.....Pewamo
Fox, Harold M.....Portland
Freiswyk, Melvin J.....(M) Belding
Geib, O. P.....Carson City
Hansen, Carl M.....Stanton
Hansen, M. M.....Greenville
Haskell, Robert H.....Northville
Hoffs, M. A.....Lake Odessa
Hollard, A. E.....Belding
Kelsey, L. E.....Lakeview
Lilly, Isaac S.....Stanton
Marston, L. L.....Lakeview
McCann, John J.....Ionia
Michmerhuizen, Robert E.....Lake Odessa
Pankhurst, C. T.....Ionia
Peabody, C. H.....(L) Lake Odessa
Reid, Harold E.....Stanton
Rice, Robert E.....Greenville
Robertson, P. C.....Ionia
Seidel, Karl E.....Ionia
Slade, H. G.....Ionia
Slagh, Milton E.....Saranac
Snider, J. D.....Ionia
Socha, Edmund S.....Ionia
Swift, E. R.....(L) Lakeview
VanLoo, J. A.....Belding
Weaver, Harry B.....Greenville
Whitten, R. R.....Ionia
Winchell, C. P.....(M) Augusta, Ga.

Jackson County

Adams, D. C.....Jackson
Ahronheim, J. H.....Jackson
Alter, R. H.....Jackson
Anderson, W. B.....Jackson
Appel, S.....Jackson
Baker, G. M.....Parma
Bartholic, F. W.....Homer
Beckwith, S. A.....Stockbridge
Binshedler, Buell S.....Jackson
Bullen, G. R.....Jackson
Chabut, H. M.....Jackson
Clarke, C. S.....Jackson
Cochrane, Wayne A.....(L) Jackson
Cooley, Randall M.....Jackson
Corley, C.....Jackson
Corley, Ennis.....Jackson
Cox, Ferdinand.....Jackson
Culver, Guy D.....Stockbridge
DeMay, C. E.....Jackson
DeMay, John.....Jackson
Deming, Richard C.....Jackson
Dengler, C. R.....Jackson
Durocher, Normand E.....Jackson
Edmonds, J. M.....Sandi, Arabia
Enders, W. H.....Jackson
Filip, H. K.....Jackson
Finton, Robert E.....(M) Jackson
Finton, Walter L.....Jackson
Fisher, Joseph V.....Chelsea
Foust, W. L.....Grass Lake
Gibson, F. J.....(L) Jackson
Gordon, D. L.....Jackson
Greenbaum, Harry.....Jackson
Growt, Bowers H.....Addison
Habenicht, Hilda.....Jackson
Hackett, T. E.....Jackson
Hackett, Thomas L.....Jackson
Hanft, Cyril F.....Springport
Hanna, R. J.....Jackson
Hardie, G. C.....Jackson
Harris, Lester J.....(E) Jackson
Hicks, Glenn C.....Jackson
Holst, John B.....Jackson
Holstein, A. P.....Manchester
Huebner, R. J.....Addison
Huntley, W. B.....Hudson
Hurley, H. L.....Jackson
Keefer, A. H.....Concord
Kudner, Don F.....Jackson
Landron, Daniel.....Michigan Center
Lathrop, Wm. W. (E).....Jackson
Leahy, E. O.....Jackson
Lenz, C. R.....Jackson
Leonard, Clyde A.....Jackson
Lewis, E. F.....Jackson
Linden, V. E.....Jackson
Ludwick, J. E.....Jackson
McGarvey, W. E.....Jackson
McLaughlin, M. J.....Jackson
McLauthlin, Herbert B.....Jackson
Meads, J. B.....Jackson
Miller, J. L.....Jackson
Miller, Samuel L.....Jackson
Munnell, Edward R...(M) Louisville, Ky.
Munro, C. D.....(E) Jackson
Munro, James E.....Jackson
Munro, Nathan D.....Jackson
Murphy, B. M.....Jackson
Newton, R. E.....Jackson
Oleksy, Stanley P.....Jackson
O'Meara, James J.....Jackson
Otis, Grant L.....Jackson
Payne, Andrew K.....Jackson
Phillips, G. H.....Jackson
Pier, C. T.....Brooklyn
Porter, Horace W.....Jackson
Pray, Frank F.....Jackson
Pray, George R.....(L) Jackson
Ransom, F. G.....Jackson
Rice, John W.....Jackson
Riley, Philip A.....Jackson
Roberts, Arthur J. (E).....Detroit
Sargent, Leland E.....Jackson
Sautter, William A.....Horton
Schmidt, T. E.....Jackson
Scott, John A.....Jackson
Shaeffer, A. M.....Jackson
Sill, Henry W.....Jackson
Sirhal, Alfred M.....Brooklyn
Smith, Dean W.....Jackson
Southwick, W. A.....Springport
Stewart, L. L.....Jackson
Stone, Ethon L.....Jackson
Sugar, Samuel .....Jackson
Susskind, M. V.....Jackson
Tate, Cecil E.....Jackson
Taylor, Ross V.....Jackson
Thayer, E. A.....Jackson
Thalner, L. F.....Jackson
Thompson, John R.....Manchester
Thompson, Tom.....Jackson
Torwick, E. T.....Jackson
Townsend, J. W.....Jackson
Van Schoick, Frank.....Jackson
Van Schoick, J. D.....Hanover
Van Wagnen, F. I.....Jackson
Vivirski, Edward E.....Jackson
Wallace, Warren S.....Jackson
Wholihan, John W.....Jackson
Wickham, W. A.....Jackson
Wilson, N. D.....(L) Jackson
Winter, George E.....(E) Jackson

Kalamazoo County

Aach, Hugo.....Kalamazoo
Alexander, C. A.....Kalamazoo
Anderson, Glenn C.....Kalamazoo
Andrews, Sherman E.....Kalamazoo
Armstrong, Robert J.....Kalamazoo
Banner, Lawrence R.....Kalamazoo
Barak, Herbert G.....Kalamazoo
Barnabee, J. W.....Kalamazoo
Barrow, Winona M.....Royal Oak
Behan, Gerald W.....Galesburg
Benjamin, Margaret H.....Kalamazoo
Bennett, Charles L.....Kalamazoo
Bennett, Keith F.....Kalamazoo
Berry, J. F.....Kalamazoo
Birch, William G.....Kalamazoo
Bodmer, H. C.....Kalamazoo
Borgman, Wallace.....Kalamazoo
Boys, Charles.....Kalamazoo
Brown, I. W.....Kalamazoo
Burbidge, Earl L.....Kalamazoo
Cobb, Horace R.....Kalamazoo
Cook, R. G.....Kalamazoo
Cooper, Paul F.....Kalamazoo
Crane, W. B.....Kalamazoo
Crawford, Kenneth L.....Kalamazoo
Dahlstrom, Doris E.....Kalamazoo
Dana, Robert L.....Kalamazoo
DeGroat, Albert.....Kalamazoo
DeWitt, L. H. (R).....Kalamazoo
DeWitt, Norman L.....Kalamazoo
Dowd, B. J.....Kalamazoo
Doyle, F. M.....Kalamazoo
Estill, Don Vincent.....(M) Kalamazoo
Farwell, Byron E.....Kalamazoo
Fast, R. B.....Kalamazoo
Fath, August F.....Kalamazoo
Fopeano, John V.....Kalamazoo
Fulkerson, C. B. .....(L) Kalamazoo
Fuller, Paul M.....Kalamazoo
Gerstner, Louis W.....Kalamazoo
Gilding, Joseph P.....Vicksburg
Goodhue, Lolita.....Kalamazoo
Grant, Frederick E.....(E) Kalamazoo
Green, William L.....Kalamazoo
Gregg, Sherman.....Kalamazoo
Hayner, R. A.....Kalamazoo
Heersma, H. S.....Kalamazoo
Hildreth, R. C.....Kalamazoo
Hodgeman, Albert B.....Kalamazoo
Hoebeke, William G.....Kalamazoo
Holder, Charles O.....Kalamazoo
Howard, H. S.....Kalamazoo
Howard, W. H.....Galesburg
Hubbell, R. J.....Kalamazoo
Huyser, William C.....Kalamazoo
Irwin, William D.....Kalamazoo
Jackson, Howard C.....Kalamazoo
Jackson, John B.....Kalamazoo
Jennings, W. O.....Kalamazoo
Kavanaugh, Wm. R.....Kalamazoo
Kilgore, Robert Nelson.....Kalamazoo
Klerk, W. J.....Kalamazoo
Koestner, Paul A.....Kalamazoo
Lambert, R. H.....Kalamazoo
Lavender, Howard C.....Kalamazoo
Light, Richard Upjohn.....Kalamazoo
Light, S. Rudolph.....Kalamazoo
Littig, John D.....Kalamazoo
MacGregor, J. R.....Kalamazoo
Machin, H. A.....Kalamazoo
Malone, James G.....Kalamazoo
Margolis, Frederick J.....Kalamazoo
Marshall, Don.....Kalamazoo
Marshall, Evelyn W.....Kalamazoo
Marshall, William P.....Kalamazoo
McCarthy, J. S.....Kalamazoo
McNabb, Arthur A.....Watervliet
Meyers, Lewis.....Kalamazoo
Moe, Carl Rex.....Kalamazoo
Morter, Roy A.....Kalamazoo
Nell, Edward R.....(M) Kalamazoo
Neubauer, Darwin W.....Kalamazoo
Nibbelink, Benjamin.....Kalamazoo
Patmos, Martin.....Kalamazoo
Pearson, Edwin O.....Kalamazoo
Peelen, J. W.....Kalamazoo
Peelen, Matthew.....Kalamazoo
Perry, Clifton W.....Kalamazoo
Prentice, Hazel R.....Kalamazoo
Prothro, W. B.....Kalamazoo
Pullon, A. E.....Kalamazoo
Rasmussen, Leo.....Vicksburg
Rigterink, G. H.....Kalamazoo
Rigterink, H. A. (L).....Kalamazoo
Rockwell, Donald C.....Kalamazoo
Russell, Stuart.....Ann Arbor
Ryan, F. C.....Kalamazoo
Sage, E. D.....Kalamazoo
Scholten, D. J.....Kalamazoo
Scholten, Wm.....Kalamazoo
Schrier, C. M.....Kalamazoo
Schrier, Paul C.....Kalamazoo
Schrier, Thomas.....Comstock
Scott, Wm. A.....Kalamazoo
Shackleton, Wm. E. (R).....Kalamazoo
Shook, R. W.....Kalamazoo
Siemsen, W. J.....Kalamazoo
Simpson, B. W.....Kalamazoo
Sisk, Wilfred N.....Kalamazoo
Snyder, Roscoe F. (L).....Kalamazoo
Sofen, Morris B.....Kalamazoo
Southworth, M. N.....Schoolcraft
Stiller, A. F.....Kalamazoo
Stryker, Homer H.....Kalamazoo
Upjohn, E. Gifford.....Kalamazoo
Upjohn, L. N.....Kalamazoo
Vander Velde, Kenneth M.....Kalamazoo
Van Urk, Thomas.....(L) Kalamazoo
Verhage, Martin D.....Kalamazoo
Volderauer, John C.....Kalamazoo
Westcott, L. P.....Kalamazoo
Wilbur, E. P.....(E) Kalamazoo
Williamson, Edwin M.....Kalamazoo
Youngs, A. S.....(E) Kalamazoo
Youngs, C. A.....Kalamazoo
Zolen, Margaret H.....Kalamazoo

Kent County

Adams, F. A.....Grand Rapids
Aitken, George T.....Grand Rapids
Albers, G. Donald.....Grand Rapids
Alfenito, Felix S.....Grand Rapids
Allen, R. V.....Grand Rapids
Andre, Harvey M.....Detroit
Avery, Noyes L.....Grand Rapids
Baert, Geo. H.....(E) Grand Rapids
Baker, Abel J.....Grand Rapids
Ballard, M. S.....Grand Rapids
Balyeat, Gordon W.....Grand Rapids
Barris, Ralph W.....Grand Rapids
Beaton, James H.....Grand Rapids
Beeman, Carl B.....Grand Rapids
Beeman, C. E.....Grand Rapids
Beets, W. Clarence.....Grand Rapids
Bell, Charles M.....Grand Rapids
Benjamin, Howard G.....Grand Rapids
Benson, Roland R.....Grand Rapids
Bergsma, Stuart.....Grand Rapids
Bettison, Wm. L.....(M) Grand Rapids
Beukema, Marenus.....Grand Rapids
Billings, Elton P.....(L) Grand Rapids
Blackburn, Henry M.....Grand Rapids
Bloxsom, Paul W.....Grand Rapids
Boelkins, Richard C.....Grand Rapids
Boersma, Donald.....Grand Rapids
Boet, F. A.....Grand Rapids
Boet, John.....Grand Rapids
Bosch, L. C.....Grand Rapids
Botting, A. J.....Byron Center
Brace, Fred.....Grand Rapids
Brayman, C. W.....(L) Cedar Springs
Brink, Russell.....Grand Rapids
Brook, Jacob D.....(L) Grandville
Brotherhood, J. S.....Grand Rapids
Browning, Eugene S.....Grand Rapids
Bruggers, Lawrence.....(M) Phillipine Is.
Buesing, O. R.....(M) Fort Dix, N. J.
Buist, S. J.....Grand Rapids
Bull, Frank L.....Sparta
Burleson, John S.....Grand Rapids
Burling, Wesley M.....Grand Rapids
Burroughs, Frank.....Grandville
Butler, Wm. J.....Grand Rapids
Byrd, Mary Lou.....Grand Rapids
Campbell, Alex. M.....(E) Grand Rapids
Carpenter, Luther C.....Grand Rapids
Cayce, William.....Grand Rapids
Chamberlain, L. H.....(L) Grand Rapids
Chandler, Donald.....Grand Rapids
Clawson, Carroll K.....Grand Rapids
Claytor, R. W.....Grand Rapids
Collisi, Harrison S.....Cleveland, Ohio
Colvin, W. G.....Grand Rapids
Corbus, Burton R.....Grand Rapids
Crane, Charles V.....Grand Rapids
Crane, Harold D.....Grand Rapids
Currier, F. P.....Grand Rapids
Dales, Ernest W.....Grand Rapids
Damstra, H. J.....Grand Rapids
Davis, D. B.....Grand Rapids
Davis, William H.....Grand Rapids
Dawson, Douglas.....Grand Rapids
Dean, Alfred W.....Grand Rapids
DeBoer, Clarence J.....(M) Grand Rapids
DeBoer, Guy Wm.....Grand Rapids
DeMaagd, Gerald.....Rockford
DeMol, Richard J.....Grand Rapids
Denham, R. H.....Grand Rapids
DePree, Isla G.....Grand Rapids
DePree, Joseph.....Grand Rapids
Deurloo, H. W.....Grand Rapids
DeVel, Leon.....Grand Rapids
DeVries, Daniel.....Grand Rapids
DeWar, M. M.....Grand Rapids
Dewey, Kent A.....Grand Rapids
Dick, Mark W.....Grand Rapids
Diskey, Donald.....Grand Rapids
Doran, Frank L.....Grand Rapids
Droste, James C.....Grand Rapids
DuBois, Wm. J.....(L) Grand Rapids
Ducey, Edward F.....Grand Rapids
Eaton, Robert M.....Grand Rapids
Eggleston, H. R.....Grand Rapids
Fahlund, George.....Grand Rapids
Failing, John F.....Grand Rapids
Farber, Charles E.....Grand Rapids
Faust, L. W.....Grand Rapids
Fellows, Kenneth E.....Grand Rapids
Ferguson, James A.....Ann Arbor
Ferguson, Lynn A.....Grand Rapids
Ferguson, Ward S.....Grand Rapids
Ferrand, Louis G.....Rockford
Fitts, Ralph L.....Grand Rapids
Flynn, J. D.....Grand Rapids
Fochtman, T. W.....Sparta
Foshee, J. C.....Grand Rapids
Frantz, Charles H.....Grand Rapids
Freyling, Robert A.....(M) Grand Rapids
Fuller, E. H.....Grand Rapids
Gamm, Kenneth.....Grand Rapids
Gibbs, F. F.....Grand Rapids
Gilbert, R. H.....Grand Rapids
Gillett, Frederick S.....(M) Grand Rapids
Grant, Lee O.....Grand Rapids
Grant, Lucile R.....Grand Rapids
Grass, Edward J.....Grand Rapids
Gray, Fred B.....Grand Rapids
Graybiel, George.....Caledonia
Griffith, L. S.....Grand Rapids
Haeck, William.....Grand Rapids
Hagerman, D. B.....Grand Rapids
Hammond, T. W.....(R) Grand Rapids
Hayes, Lawrence W., Sr.....Howard City
Hayes, Lawrence W., Jr.....Sand Lake
Heetderks, Dewey.....Grand Rapids
Henry, James, Jr.....Grand Rapids
Herrick, Ruth.....Grand Rapids
Hill, A. Morgan.....Grand Rapids
Hodgen, J. T.....Grand Rapids
Holcomb, J. W.....Grand Rapids
Holdsworth, M. J.....Grand Rapids
Holkeboer, Henry D.....Grand Rapids
Hollander, Stephen.....Grand Rapids
Hoogerhyde, Jack.....Grand Rapids
House, Glenn W.....Grand Rapids
Hufford, A. R.....Grand Rapids
Hunderman, Edward.....Grand Rapids
Hyland, W. A.....Grand Rapids
Jack, William.....Denver, Colo.
Jameson, Fred M.....Grand Rapids
Jaracz, W. J.....Grand Rapids
Jarvis, Charles.....Grand Rapids
Jellema, J. F.....Grand Rapids
Jones, H. C.....Grand Rapids
Kelly, Edward F.....Grand Rapids
Kemmer, Thomas R.....Grand Rapids
Kendall, Eugene L.....Grand Rapids
Kielhorn, Walter P.....Grandville
Klaus, C. D.....Grand Rapids
Kniskern, P. W.....Grand Rapids
Kooistra, Henry P.....Grand Rapids
Koon, William D.....(M) Detroit
Kremer, John.....(L) Grand Rapids
Kreulen, H. J.....Grand Rapids
Kriekard, P. J.....(L) Grand Rapids
Krupp, C. G.....Grand Rapids
Laird, Robert G.....Grand Rapids
Lanning, N. E.....Grand Rapids
Lentini, Joseph R.....Grand Rapids
Le Roy, Simeon.....Grand Rapids
Lieffers, Harry.....Grand Rapids
Lindenfeld, Fred. H.....(M) Grand Rapids
List, Carl F.....Grand Rapids
Logie, James W.....Grand Rapids
Lyman, William D.....(L) Grand Rapids
MacDonell, James A.....Lowell
Marsh, John P.....Grand Rapids
Maynard, Mason S.....Grand Rapids
McCandliss, Robert.....Grand Rapids
McCormick, John.....Grand Rapids
McDougal, Wm. J.....Grand Rapids
McDougall, Clarice.....Grand Rapids
McKenna, J. L.....Grand Rapids
McKinley, L. M.....Grand Rapids
McRae, John H.....Grand Rapids
Meade, Richard H., Jr.....Grand Rapids
Mehney, Gayle H.....Grand Rapids
Miller, J. Duane.....Grand Rapids
Miller, John J.....Marne
Mitchell, W. B.....Grand Rapids
Moen, Cornetta G.....Grand Rapids
Moleski, Joseph.....Grand Rapids
Moleski, Leo T.....Grand Rapids
Moleski, Stanley L.....Grand Rapids
Moll, Arthur M.....Grand Rapids
Morey, Edward C.....Grand Rapids
Mouw, Dirk.....Grand Rapids
Mulder, J. D.....Grand Rapids
Murphy, M. J.....Grand Rapids
Nelson, A. R.....San Francisco, Calif.
Noordewier, Albert.....(L) Grand Rapids
Northouse, Peter B.....Grand Rapids
Notier, Victor.....Grand Rapids
Oliver, W. W.....Grand Rapids
Olson, John R.....Grand Rapids
Osborn, Howard.....Grand Rapids
Paalman, Russell J.....Grand Rapids
Patterson, P. Wilfred.....Grand Rapids
Payne, C. Allen.....Grand Rapids
Pearson, Glenn A.....Grand Rapids
Pedden, J. R., Jr.....Grand Rapids
Plekker, J. D.....Grand Rapids
Posthuma, A. E.....(M) Address Unknown
Posthuma, Millard.....(M) Grand Rapids
Pyle, Henry J.....Grand Rapids
Quirk, Edmund J.....Grand Rapids
Ragsdale, L. V.....Grand Rapids
Ralph, L. Paul.....Grand Rapids
Rasmussen, Richard A.....Grand Rapids
Reed, Torrance.....Grand Rapids
Reus, William F.....Grand Rapids
Rigterink, J. W.....Grand Rapids
Riley, G. L.....Grand Rapids
Robb, Charles S.....Grand Rapids
Roberts, Mortimer E.....(E) Grand Rapids
Robinson, Harold C.....Grand Rapids
Rodgers, William L.....Grand Rapids
Rosenzweig, Leonard.....Grand Rapids
Roth, Emil M.....Grand Rapids
Ryan, John A.....Grand Rapids
Schaubel, Howard J.....Grand Rapids
Schermerhorn, L. J.....Grand Rapids
Schnoor, E. W.....Grand Rapids
Schnute, Louise F.....Grand Rapids
Schuitema, Donald.....Grand Rapids
Sculley, Ray E.....Grand Rapids
Sevensma, Elisha S.....Grand Rapids
Sevensma, Eugene S.....Grand Rapids
Sevey, L. E.....Grand Rapids
Shellman, Millard W.....Grand Rapids
Shepard, B. H.....Lowell
Sherwood, J. Vincent.....Grand Rapids
Sidell, Chester M.....Grand Rapids
Sidell, Richard H.....Grand Rapids
Slemmons, C. G.....(L) Grand Rapids
Sluyter, J. S.....Grand Rapids
Smith, A. B.....Grand Rapids
Smith, Edwin M.....Grand Rapids
Smith, Ferris N.....Grand Rapids
Smith, R. Earle.....Grand Rapids
Smith, Robert B.....Grand Rapids
Snyder, Clarence.....Grand Rapids
Southwick, G. Howard.....Grand Rapids
Steffensen, W. H.....Grand Rapids
Stonehouse, G. G.....Grand Rapids
Stover, Virgil E.....Grand Rapids
Sugg, Cullen E.....Grand Rapids
Sugiyama, Titsuo.....Grand Rapids
Sus Strong, Carl A.....Grand Rapids
Swenson, H. C.....Grand Rapids
Swenson, Leland L.....(M) Grand Rapids
Ten Have, J.....Grand Rapids
Tesseine, A. J.....Grand Rapids
Teusink, J. H.....Cedar Springs
Thompson, A. B.....(E) Grand Rapids
Thompson, Athol B.....Grand Rapids
Thompson, Edw.....Grand Rapids
Thompson, Frank D.....Grand Rapids
Tidey, Marcus B.....Grand Rapids
Tiffany, Jos. C.....Grand Rapids
Torgerson, Wm. R.....Grand Rapids
Truog, Clarence P.....Grand Rapids
Van Belois, Harvard J.....Grand Rapids
Van Bree, R. S.....Grand Rapids
Vanden Berg, Henry J.....Grand Rapids
Van Duine, H. J.....Grand Rapids
Van Noord, Gelmer A.....Grand Rapids
Vann, Norman S.....Grand Rapids
Van't Hof, A.....Grand Rapids
Van Pernis, Paul A.....Grand Rapids
Van Solkema, Andrew.....Grand Rapids
Van Solkema, Arthur.....Grandville
Van Woerkom, Daniel.....Grand Rapids
Van Zwaluwenburg, Benj. R.....Grand Rapids
Veldman, Harold E.....Grand Rapids
Venema, J. R.....Grand Rapids
Ver Meulen, John.....Wyoming Park
Vining, Keats K., Jr.....Lowell
Vis, William R.....Grand Rapids
Vyn, J. D.....Grand Rapids
Webber, Jerome.....Grand Rapids
Wedgewood, L. G.....Grandville
Wells, Merrill.....Grand Rapids
Wenger, A. V.....Grand Rapids
Wenger, John N.....Coopersville
Whalen, John M.....(M) Grand Rapids
Whinery, Joseph B.....Grand Rapids
Whinery, Joseph F.....Grand Rapids
Willits, P. W.....Grand Rapids
Wilson, Wm. E.....(R) Grand Rapids
Wright, Thomas B.....Grand Rapids
Yegge, J. P.....Kent City

Lapeer County

Allen, Samuel S.....Lapeer
Best, Herbert M.....Lapeer
Bishop, G. C.....Almont
Burley, David H.....(E) Almont
Chapin, Clarence D.....Columbiaville
Clarke, Dorland.....Lapeer
Doty, James R.....Lapeer
McBride, J. R.....Lapeer
Merz, Henry G.....(E) Lapeer
O'Brien, Daniel J.....Lapeer
Palmer, Fred W.....Lapeer
Rehn, Adolph T.....Lapeer
Smith, G. L.....Imlay City
Thomas, J. Orville.....(E) North Branch
Zemmer, H. B.....Lapeer
Zolliker, Carl R.....Imlay City

Lenawee County

Abraham, A. O.....Hudson
Allen, R. A.....Adrian
Beebe, I. J.....Johnston, Pa.
Blair, Thomas H.....Adrian
Blanchard, L. E.....Hudson
Blanden, Merwin R.....Tecumseh
Claxton, W. T.....Britton
Colbath, W. E.....Adrian
DeRyke, Gilbert R.....Adrian
Dickman, Harry M.....Hudson
Dustin, Richard E.....Tecumseh
Hammel, H. H.....Tecumseh
Hardy, P. B.....Tecumseh
Heffron, Charles.....Adrian
Heffron, Howard H.....Adrian
Helzerman, Ralph F.....Tecumseh
Hewes, A. B.....Adrian
Hewes, William.....Adrian
Hinshaw, W. V.....Adrian
Hornsby, W. B.....Clinton
Huntley, H. C.....Adrian
Isley, H. E.....Blissfield
Jewett, Wm. E., Jr.....Adrian
Loveland, Horace H.....Tecumseh
MacKenzie, W. S.....Adrian
McCue, Francis J., Jr.....Adrian
Marsh, R. G. B.....Tecumseh
Mast, W. H.....Tecumseh
Miller, Perry Lynford.....Adrian
Morden, Esli T.....Adrian
Pasternacki, Arthur S.....Adrian
Patmos, Bernard.....Adrian
Purfield, Wm. .....Clinton
Raabe, E. C.....Morenci
Rogers, J. D.....Adrian
Sayre, Phillip P.....Onsted
Spalding, I. L.....Hudson
Stafford, Leo.....Adrian
Tubbs, R. V.....Blissfield
Van Dusen, C. A.....Blissfield
Whitehouse, Keith.....Morenci
Wynn, G. H.....Adrian

Livingston County

Clarke, Niles A.....Brighton
Crandell, Claire H.....Howell
Duffy, Ray M.....Pinckney
Fidler, Fred W.....Howell
Finch, E. D.....Howell
Glenn, Bernard H.....Fowlerville
Hendren, J. J.....Fowlerville
Hill, Harold C.....Howell
Huntington, H. G.....Howell
Laboe, Edward W.....Howell
Leslie, G. L.....Pontiac
Lieber, R. W.....Howell
McDowell, Guy M.....Grosse Pte. Woods
Oleen, George G.....Howell
Perry, Florence J. C.....Howell
Rednor, Daniel J.....(A) Howell
Sigler, Hollis L.....Howell
Whitehouse, Walter M.....Howell

Luce County

Campbell, Earl H.....Newberry
Gibson, Robert E.....Newberry
Koss, Frank R.....Newberry
Perry, M. E.....Newberry
Purmort, William R., Jr.....Newberry
Surrell, Mathew A.....Newberry

Macomb County

Allen, Leroy K.....Roseville
Banting, O. F.....Richmond
Barker, John G.....Center Line
Bower, A. B.....Armada
Brady, Milo J.....St. Clair Shores
Bryce, James W.....Centerline
Buckley, D. J.....Mt. Clemens
Croman, Joseph Wm., Jr.....Mt. Clemens
Curlett, James E.....(L) Roseville
Dudzinski, Edmund J.....New Baltimore
Engels, J. A.....Richmond
Heine, Austin W.....Mt. Clemens
Isbey, Edward K.....Center Line
Jewell, James H.....Mt. Clemens
Juliar, Joseph F.....Mt. Clemens
Kane, Wm. J.....Mt. Clemens
Lane, W. D.....Romeo
Lynch, Russell.....Center Line
Maguire, A. J.....Utica
Miller, Sidney S.....East Detroit
Moore, G. F.....Mt. Clemens
Mulligan, P. T.....Mt. Clemens
Morgan, Parker B.....Utica
Reichman, Joseph J.....Mt. Clemens
Reitzel, R. H.....Mt. Clemens
Rivard, Charles L.....Grosse Pointe Woods
Roth, G. E.....Detroit
Rothman, A. M.....East Detroit
Ruedisueli, Clarence A.....Roseville
Salot, R. F.....Mt. Clemens
Scher, Joseph N.....Mt. Clemens
Scher, Sydney.....Mt. Clemens
Siegfried, E. G.....New Haven
Singer, Nelson.....East Detroit
Smith, Milton C.....Mt. Clemens
Stone, Elizabeth A.....Romeo
Stryker, O. D.....Mt. Clemens
Sturm, Fred A.....St. Clair Shores
Thompson, A. A.....Mt. Clemens
Ullrich, R. W.....Mt. Clemens
Wellard, Henry C.....New Baltimore
Whitley, Alec.....St. Clair Shores
Wilde, M. M.....Warren
Wiley, D. Bruce.....Utica
Wolfson, Victor H.....Mt. Clemens

Manistee County

Grant, C. L.....Manistee
Hansen, E. C.....Manistee
Konopa, John F.....Manistee
Lalime, Ruth E.....Bear Lake
Lewis, Lee A.....(E) Manistee
MacMullen, Harlen.....(R) Manistee
Miller, E. B.....Manistee
Murphy, Frank E.....Cadillac
Norconk, Ward H.....Bear Lake
Oakes, Ellery A.....Manistee
Ogilvie, G. D.....Manistee
Quinn, Henry M.....Copemish
Ramsdell, Homer A.....Manistee
Rowe, Robert E.....Manistee
Switzer, Lars W.....Manistee

Marquette-Alger Counties

Acocks, J. R.....Marquette
Baron, Benzoin C.....Munising
Bennett, Arthur K.....Marquette
Bennett, M. C.....Marquette
Berry, Robert F.....Marquette
Bertucci, J. P.....Ishpeming
Burke, R. A.....Negaunee
Casler, W. L.....Marquette
Cooperstock, M.....Marquette
Corcoran, W. A.....Ishpeming
Drury, Chas. P.....Marquette
Elizinga, Eugene R.....Marquette
Erickson, Arvid W.....Ishpeming
Fennig, F. A.....Marquette
Green, Southgate J.....Gwinn
Harsh, R. C.....Pontiac
Hirwas, C. L.....Marquette
Hornbogen, D. P.....Marquette
Howe, L. W.....Marquette
Keskey, George I.....Marquette
Knudson, George.....Negaunee
Lambert, W. C.....Marquette
LeGolvan, C.....Marquette
Lyons, James.....(M) Marquette
McCann, Neal J.....Marquette
Mudge, W. A.....Negaunee
Narotzky, Archie S.....Ishpeming
Nicholson, J. B.....Marquette
Paine, Raymond Lee.....Negaunee
Robbins, Nelson J.....(L) Negaunee
Schweinsberg, Sara D.....Marquette
Serbst, Charles.....Marquette
Sicotte, Isaiah.....Michigamme
Swinton, A. L.....Marquette
Talso, Jacob.....Ishpeming
Tearnan, Raymond A.....Munising
Van Riper, Paul.....(L) Champion
Waldie, George McLeod.....Ishpeming
Wickstrom, Geo.....Munising
Williams, R. G.....Ishpeming

Mason County

Blanchette, Victor J.....Scottville
Boldyreff, Ephraim.....Custer
Comodo, Nicholas M.....Ludington
Fenneman, Robert J.....Scottville
Goulet, L. J.....Ludington
Hoffman, Howard.....Ludington
Lintner, Roy C.....Ludington
Martin, Wm. S.....Ludington
Ostrander, R. A.....Ludington
Paukstis, Charles.....Ludington
Scott, Robert Redvers.....Ludington
Slaybaugh, J. C.....Ludington

Mecosta-Osceola-Lake Counties

Bruggema, Jacob.....Evart
Chess, Leo F.....Reed City
Franklin, Benjamin L.....Remus
Ikovich, Paul.....Reed City
Kilmer, David.....Reed City
Kilmer, Paul B.....Reed City
Kowaleski, Edward.....Remus
Merlo, F. A.....Big Rapids
Mitchell, H. C.....Big Rapids
Nelson, Lorenzo.....Baldwin
Treynor, Thomas P.....Big Rapids
Van Auken, Edward A.....Big Rapids
White, J. A.....Big Rapids
Yeo, Gordon H.....Big Rapids

Medical Society of North Central Counties

Boehm, John D.....(R) West Branch
Clippert, C. G.....Grayling
Coulter, Keith Douglas.....Gladwin
Drescher, Geo. A.....Lewiston
Egle, Joseph L.....Gaylord
Forney, F. A.....Gaylord
Hasty, Earl.....West Branch
Jardine, Hugh M.....West Branch
Keyport, C. R.....Grayling
Libke, Robert.....Gaylord
Martzowka, M. A.....Roscommon
McDowell, D. B.....West Branch
McKillop, G. L.....Gaylord
Palm, Geo.....Pruddenville
Peckham, Richard.....Gaylord
Stealy, Stanley.....Grayling

Menominee County

Brukardt, Herman R.....Menominee
Clark, E. R.....Powers
DeWane, F. J.....Menominee
Dewane, James N.....(M) Menominee
Flanagan, Clarence B.....Menominee
Glickman, L. Grant.....Marinette, Wis.
Heidenreich, John R.....Daggett
Jones, Wm. S.....Menominee
Kaye, J. T.....Menominee
Kerwell, K. C.....Stephenson
Peterson, A. R.....Daggett
Sawbridge, Edward.....(E) Stephenson
Schroeder, J. M.....Menominee
Sethney, Henry T.....Menominee
Towey, J. W.....Powers

Midland County

Ballmer, Robert S.....Midland
Bowsher, Robert E.....Midland
Bulmer, Dan J.....Midland
Buskirk, Maurice D.....Midland
Cronemeyer, William H.....Midland
Gay, Harold H.....Midland
Gordon, Harold L.....Midland
Grewe, N. C.....Midland
Hautau, Emily.....Midland
High, C. V., Jr.....Midland
Howe, Irvin M.....Midland
Ittner, Martin.....Midland
Linsenman, Karl W.....Midland
MacCallum, Charles.....Midland
Maynard, W. A.....Coleman
Meisel, Edward H.....Midland
Pike, Melvin H.....Midland
Sherk, J. H.....Midland
Towsley, W. D.....Midland

Monroe County

Acker, Wm. F.....Monroe
Ames, Florence.....Monroe
Barker, Vincent L.....Monroe
Blakey, L. C.....Monroe
Bond, W. W.....Monroe
Cigany, Zoltan B.....Carleton
Dusseau, S. V.....(E) Erie
Ewing, R. T.....Monroe
Flanders, J. P.....Monroe
Frary, R. A.....Monroe
Gelhaus, Wm. J.....Monroe
Golinvaux, C. J.....Monroe
Hensel, Hilda.....Monroe
Hunter, M. A.....Monroe
Johnson, A. Esther.....Monroe
Kelso, Newton S., Jr.....Monroe
Landon, Herbert W.....Monroe
Long, Edgar C.....Monroe
Long, Sara.....Monroe
Mather, C. B.....Monroe
McDonald, T. A.....Monroe
McGeoch, R. W.....Monroe
McMillin, J. H.....Monroe
Meck, H. L.....Dundee
Newcomer, Sheldon R.....Monroe
Parmelee, O. E.....Lambertville
Pinkus, Hermann.....Monroe
Reisig, A. H.....Monroe
Sanger, Emerson J.....Monroe
Wagar, Spencer.....Rockwood
Williams, Robert J.....Monroe
Williamson, G. W.....Dundee

Muskegon County

Anderson, A. J.....Muskegon
Anderson, Axel W.....Lakewood Club
August, R. V.....Muskegon Heights
Bailey, Robert S.....Muskegon
Barnard, Helen.....Muskegon
Benedict, A. L.....Muskegon
Bloom, C. J.....Muskegon
Boyd, D. R.....Muskegon
Boyd, Jack L.....(A) Muskegon
Bradshaw, Park S.....Muskegon
Chapin, Wm. S.....(A) Muskegon Heights
Christophersen, J. W.....Muskegon
Clapp, Henry W.....Muskegon
Cohan, Sol G.....Muskegon
Dasler, A. F.....Muskegon
Derezinski, Clement F.....Muskegon
Diskin, Frank.....Muskegon
Douglas, Robert.....Muskegon
Durham, C. J.....Muskegon
Dykhuizen, Harold D.....Muskegon
Eckerman, C. T.....Muskegon
Fillingham, Enid.....Muskegon
Fleischmann, C. B.....Muskegon
Fleishman, Norman.....Muskegon
Foss, Ed. O.....Muskegon
Gaikema, E. W.....Muskegon
Garber, F. W., Jr.....Muskegon
Gillard, James.....Muskegon
Goltz, Martha.....Montague
Greene, Henry Phillip.....Muskegon
Griffith, Robert M.....Muskegon
Hagen, William A.....Muskegon
Hanley, William J.....Muskegon
Hannum, F. W.....Muskegon
Harrington, A. F.....Muskegon
Hartwell, S. W.....Muskegon
Heneveld, Edw. H.....Muskegon
Heneveld, John.....Muskegon
Holly, Leland E.....Muskegon
Holmes, Roy Herbert.....Muskegon
Joistad, A. H.....Muskegon
Jiroch, John T.....Muskegon
Kane, Thomas J.....Muskegon
Kay, Ceceilia.....Muskegon
Keilin, Marie.....Muskegon
Kerr, H. J.....Muskegon
Lange, E. W.....Muskegon
Lauretti, Emil.....Muskegon
Laurin, V. Samuel.....Muskegon
LeFevre, Louis.....Muskegon
LeFevre, Wm. M.....Muskegon
Loder, Leonel Lewis.....Muskegon
Loomis, John L.....Muskegon
Mandeville, C. B.....Muskegon
Medema, Paul.....Muskegon
Meengs, M. B.....Muskegon
Miller, Philip L.....Muskegon
Morford, F. N.....Muskegon
Mulligan, A. W.....Muskegon
Oden, Constantine L.....Muskegon
Petkus, Antonie.....Muskegon Heights
Pettis, Emmett.....Muskegon
Powers, Lunette.....(E) Muskegon
Price, Leonard.....Muskegon
Pyle, H. J.....Muskegon
Risk, R. A.....Muskegon
Risk, Robert D.....Muskegon
Scholle, Norbert.....Muskegon
Sears, Richard.....Muskegon
Shebasta, Emil.....Muskegon
Smith, M. Luther.....Muskegon
Swartout, W. C.....Muskegon
Teifer, Charles A.....Muskegon
Theime, S. W.....Ravenna
Thornton, E. S.....Muskegon
Toy, Charles.....Muskegon
Vanderlaan, John E.....Muskegon
Wagenaar, E. H.....Muskegon
Wiersma, Silas C.....Muskegon
Wilke, C. A.....Montague
Williams, E. V.....Muskegon Heights
Wilson, P. S.....Muskegon

Newaygo County

Cook, J. Maxwell.....White Cloud
Deur, T. R.....Grant
Geerlings, Lambert.....Fremont
Geerlings, Ralph Willis.....Fremont
Harris, Dean W.....Fremont
Klein, J. Paul.....Fremont
Masters, Brooker L.....Fremont
Moore, H. R.....Newaygo
O'Neill, J. W.....White Cloud
Tompsett, Arthur C.....Hesperia

Northern Michigan

Albi, Robert J.....Boyne City
Alm, Bernhard T.....Petoskey
Blum, Benj. B.....Petoskey
Burns, Dean C.....Petoskey
Chapman, Willis Earl.....(E) Cheboygan
Conkle, Guy C.....Boyne City
Conti, Joseph.....Petoskey
Conway, Wm. S.....Petoskey
Duffie, Don Hastings.....Central Lake
Elliott, E. James.....Boyne City
Gervers, J. H. R.....Bellaire
Grate, L.....Charlevoix
Hegener, A. J.....Petoskey
Larson, Walter E.....Cheboygan
Lashmet, Floyd H.....Petoskey
Lentini, Nicholas.....Cheboygan
Lilga, Harris V.....Petoskey
Litzenburger, A. F.....Boyne City
Mayne, Frederick C.....Cheboygan
McClintock, Robert S.....Charlevoix
Palmer, Russell.....St. James
Parks, W. H.....Petoskey
Rodger, John.....Bellaire
Saltonstall, Gilbert B.....Charlevoix
Savory, John H.....East Jordan
Stringham, J. R.....Cheboygan
Van Dellen, Jerrian.....East Jordan
Van Heldorf, Harry.....Boyne City
Weeberg, Kathryn.....Petoskey
Wood, George H.....Onaway

Oakland County

Abbott, V. C.....Pontiac
Adams, Frederick M.....Birmingham
Arnkoff, Harry.....Pontiac
AschenBrenner, Z. R.....Farmington
Baker, Robert H.....Pontiac
Bannow, Robert J.....Pontiac
Barker, Howard B.....Pontiac
Bauer, Edward G.....Pontiac
Bauer, Ernest G.....Hazel Park
Beattie, W. G.....Ferndale
Beck, Otto O.....Birmingham
Blakeney, James R.....Auburn Heights
Blue, Jane.....Elizabeth Lake
Boucher, R. E.....Royal Oak
Burke, Chauncey G.....Pontiac
Butler, Samuel A.....Pontiac
Calhoun, Ethel T.....Birmingham
Campbell, Malcolm D.....Ferndale
Cefai, A. F.....Pontiac
Christie, Edward.....Pontiac
Christie, J. W.....Pontiac
Cobb, Leon F.....Pontiac
Cobb, Thomas H.....Pontiac
Collins, Edward F.....Pontiac
Cooper, Robert J.....Pontiac
Cooley, Roy V., Jr.....Pontiac
Couche, Henry O.....Birmingham
Crissman, Harold C.....Ferndale
Cudney, Ethan B.....Pontiac
Currier, R. Keith.....Pontiac
Dahlgren, Carl.....Keego Harbor
Darling, C. G., Jr.....Pontiac
Deutsch, Wm. L.....Huntington Woods
Dobski, Edwin J.....Pontiac
Dunlap, Gregg L.....Keego Harbor
Dunn, Lewis E.....Berkley
Ekelund, Clifford T.....Pontiac
Endress, Zac.....Pontiac
Farnham, Lucius Augustine.....Pontiac
Ferris, Ralph G.....Birmingham
Fitzpatrick, Francis.....Pontiac
Flick, Earl J.....Royal Oak
Flick, John R.....Royal Oak
Foust, Earl W.....Hazel Park
Furlong, Harold A.....Pontiac
Gaensbauer, Ferdinand.....Pontiac
Gariepy, Bernard F.....Royal Oak
Gatley, C. R.....Pontiac
Gatley, L. Warren.....Pontiac
Gehringer, Norman F.....Pontiac
Geib, Ormond D.....Rochester
Gerls, Frank B.....Pontiac
Gibson, James C.....(E) Milford
Gibson, Wellington C.....Pontiac
Gill, Matthew J.....Pontiac
Grant, William A.....Milford
Green, James D.....Birmingham
Green, Wm. M.....Pontiac
Hackett, Daniel Jos.....Pontiac
Haddock, D. A.....Pontiac
Hageman, George.....Bloomfield Hills
Halsted, Lee H.....Farmington
Hammonds, E. E.....Birmingham
Harvey, Campbell.....Pontiac
Hasner, Robert B.....Royal Oak
Hassberger, J. B.....Birmingham
Hathaway, Clarence L.....Lake Orion
Hathaway, William.....Rochester
Henry, Colonel R.....Ferndale
Hensley, C. B.....Lake Orion
Howlett, E. V.....Pontiac
Hubert, John R.....Pontiac
Hurst, Daniel D.....Pleasant Ridge
Hutchinson, W. G.....(L) Pontiac
Kemp, Felix J.....Pontiac
Kemp, W. Lloyd.....Birmingham
Koehler, William B.....Royal Oak
Lambie, John S.....Birmingham
Lambert, Alvin Gerald.....Ferndale
Larson, Alvin R.....Pontiac
Lewis, S. M.....Ferndale
Lockwood, C. E.....Holly
Mackenzie, O. R.....Walled Lake
Margrave, Edmund C.....Royal Oak
Markley, John Martin.....Pontiac
Mason, Robert J.....Birmingham
McConkie, J. P.....Birmingham
McEvoy, Francis J.....Royal Oak
McNeill, H. H.....Pontiac
Mehas, C. P.....Pontiac
Meinke, Herman A.....Hazel Park
Mercer, Frank A.....Pontiac
Merrill, Lionel N.....Royal Oak
Mershon, R. B.....Royal Oak
Miller, Hazel L.....Royal Oak
Miller, Sidney.....Birmingham
Mitchell, B. M.....Pontiac
Monroe, John D.....Pontiac
Morton, James A.....Pontiac
Neafie, Chas. A.....Pontiac
Newcomb, Arnold B.....Berkley
Norup, John.....Berkley
Nosanchuk, Joseph.....Pontiac
Olsen, Richard E.....Pontiac
Palmer, Hayden.....Pontiac
Pauli, Theodore H.....Pontiac
Payton, Charles F.....Royal Oak
Pelletier, Charles J.....Hazel Park
Petroff, George N.....Pontiac
Porritt, Ross J.....Pontiac
Ports, Preston W.....Farmington
Prevette, Isaac C.....Pontiac
Quarton, Albert E.....Birmingham
Raynale, George P.....Birmingham
Reid, Fred T.....Clawson
Riggs, Harry L.....Pontiac
Riker, Aaron D.....Pontiac
Roehm, Harold.....Birmingham
Rowley, Laurie G.....Drayton Plains
Rupp, Edson C.....Royal Oak
Russell, Vincent P.....Royal Oak
Ruva, Joseph.....Pontiac
St. John, Harold A.....Pontiac
Schlecte, Carl.....Rochester
Schoenfeld, John B.....Birmingham
Schuneman, Howard.....Ferndale
Seaborn, A. J.....Royal Oak
Shadley, Maxwell.....Pontiac
Sheffield, L. C.....Pontiac
Sibley, H. A.....Pontiac
Simpson, E. K.....Pontiac
Smith, Carleton A.....Pontiac
Smith, Donald S.....Pontiac
Smith, Ellen.....Pontiac
Smith, George E.....Royal Oak
Spencer, Lloyd H.....Royal Oak
Spoehr, Eugene L.....Ferndale
Spohn, Earl W.....Royal Oak
Stageman, John Condon.....Pontiac
Stahl, Harold F.....Oxford
Stanley, Wm. F.....Ferndale
Starker, Clarence T.....Pontiac
Steffes, Everette.....Berkley
Steinberg, Norman.....Royal Oak
Stolpman, A. K.....Birmingham
Sutton, Palmer E.....Royal Oak
Swickle, Edward F.....Clawson
Tauber, A.....Pontiac
Tuck, Raymond G.....Pontiac
Uloth, Milton J.....Ortonville
Van Haltern, H. L.....Pontiac
Wagner, Ruth E.....Royal Oak
Wake, Douglas L.....Royal Oak
Watson, Thomas Y.....Birmingham
Wessels, Robert R.....Birmingham
Wigent, Ralph D.....Pontiac
Williams, John P.....Pontiac
Young, Arthur R.....Pontiac

Oceana County

Flint, Charles.....Hart
Hasty, Willis A.....Shelby
Hayton, A. R.....Shelby
Heard, Wm.....Pentwater
Munger, L. P.....(E) Hart
Nicholson, John H.....(E) Hart
Reetz, Fred A.....(A) Shelby
Robinson, W. Gordon.....Hart
Wood, Merle G.....Hart

Ontonagon County

Bender, Jesse L.....Mass
Hogue, H. B.....Ewen
Rubinfeld, S. H.....Ontonagon
Strong, W. F.....Ontonagon

Ottawa County

Barrett, C. Dale.....Grand Haven
Beernink, E. H.....Grand Haven
Bloemendaal, D. C.....Zeeland
Blomendal, W. B.....Grand Haven
Boone, Cornelius E.....Zeeland
Bulthuis, Jerry E.....Jamestown
Clark, Nelson H.....Holland
Cook, Carl S.....Holland
DeVries, H. G.....Holland
DeYoung, Fred.....Spring Lake
Hager, Ralph.....Hudsonville
Hamelink, H. M.....Holland
Harms, H. P.....Holland
Kemme, Gerrit.....Zeeland
Kitchel, John.....Grand Haven
Kitchel, Mary.....Grand Haven
Kools, William Clarence.....Holland
Leenhouts, Abraham.....(E) Holland
Long, C. E.....Grand Haven
Nichols, Rudolph H.....Holland
Nykamp, Russell.....Zeeland
Presley, Wm. J.....(L) Grand Haven
Rypkema, Willard M.....Grand Haven
Schalftenaar, R. H.....Holland
Schrick, Edna C.....Holland
Ten Have, Ralph.....Grand Haven
Timmerman, E. C.....Coopersville
Van Appiedorn, C. J.....Holland
Van Der Berg, E.....Holland
Van Kolken, P. J.....Grand Haven
Vander Velde, O.....Holland
Wells, Kenneth.....Spring Lake
Westrate, William.....Holland
Winter, John K.....Holland
Winter, Wm. G.....Holland
Yonkman, F. F.....Madison, N. J.

Saginaw County

Ackerman, G. L.....Saginaw
Anderson, W. K.....Saginaw
Bagley, U. S.....Saginaw
Berberovich, T. F.....Saginaw
Brender, Fred P.....Frankenmuth
Brock, W. H.....(L) Saginaw
Bruton, Martin F.....Saginaw
Bucklin, Robert.....Saginaw
Bullington, Bert Montell.....Saginaw
Busch, Frank J.....Saginaw
Butler, M. G.....Saginaw
Button, A. C.....Saginaw
Cady, F. J.....Saginaw
Cameron, Allen K.....Saginaw
Campbell, L. A.....Saginaw
Catizone, Roy J.....Merrill
Chisena, Peter R.....Bridgeport
Clark, Wilbert.....(L) Kenmore, N. Y.
Claytor, A. A.....Saginaw
Cody, Frederick J.....Saginaw
Cortopassi, Andre.....Saginaw
Cortopassi, V. E.....Saginaw
Cory, C. W.....Saginaw
Curts, James.....Saginaw
Durman, Donald C.....Saginaw
Ely, C. W.....Saginaw
Ernst, Arthur R.....Saginaw
Eymer, Esther.....Saginaw
Fleschner, Thomas E.....Birch Run
Galsterer, Edwin C.....Saginaw
Gardner, Joe H.....Saginaw
Goman, Louis D.....Saginaw
Grigg, Arthur.....(E) Saginaw
Grigg, Arthur P.....Saginaw
Hand, Eugene A.....Saginaw
Helmkamp, H. O.....Saginaw
Hester, E. G.....Saginaw
Hohn, Fred, Jr.....Saginaw
Howell, Don M.....Saginaw
Jaenichen, R.....Saginaw
Jiroch, R. S.....Saginaw
Jordan, Leo A.....Saginaw
Kemp, J. N.....(L) Saginaw
Kempton, R. M.....Saginaw
Kerr, William.....Saginaw
Keyes, James T.....Birch Run
Kirchgeorge, Clemens G.....Frankemuth
Kleekamp, Herbert G.....Saginaw
Klippen, Arthur J.....Saginaw
Kowals, F. V.....Saginaw
La Porte, Lawrence A.....Saginaw
Ling, Ernest M.....Hemlock
Ling, Kenneth C.....Hemlock
Lohr, O. W.....Saginaw
Longstreet, Martha L.....Saginaw
Luger, F. E.....Saginaw
Lyle, R. C.....Bridgeport
MacKinnon, Edwin D.....Saginaw
MacMeekin, James Ware.....Saginaw
Manning, John E.....Saginaw
Martzowka, Wm. P.....Saginaw
Matthews, Harry C.....Saginaw
Maurer, John A.....Saginaw
Mayne, Harold.....Saginaw
McKinney, Alex R.....Saginaw
McLandress, Joshua A.....(L) Saginaw
Meyer, Henry J.....(E) Saginaw
Mikan, V. Robert.....Saginaw
Morgrette, Leonard.....Saginaw
Murphy, Albert P.....Saginaw
Murray, M. J.....Saginaw
Nelson, Oscar A.....Saginaw
Nicholas, Mildred.....Saginaw
Northway, Robert O.....Saginaw
Novy, F. O.....Saginaw
Olson, Porter.....Saginaw
Ostrander, Frank W.....Freeland
Phillips, Homer A.....Saginaw
Pietz, Frederick.....Saginaw
Pillsbury, Edward A.....Frankenmuth
Poole, Frank A.....(L) Saginaw
Richards, Ned W.....Saginaw
Richter, Harry J.....Saginaw
Ryan, M. D. .....(E) Saginaw
Ryan, R. S.....Saginaw
Sample, J. T.....Saginaw
Sargent, D. V.....Saginaw
Schaiberger, Elmer G.....Saginaw
Sharp, Martin C.....Saginaw
Sheldon, S. A.....Saginaw
Siler, Delbert E.....Saginaw
Skowronski, Casimer A.....Saginaw
Slack, Walter K.....Saginaw
Stahly, Edward H.....Saginaw
Stander, A. C.....Saginaw
Stewart, George W.....Saginaw
Toshach, C. E.....Saginaw
Volk, V. K.....Saginaw
Wallace, Herbert C.....Saginaw
Westlund, Norman.....Saginaw
Wilson, H. Roy.....(R) Saginaw
Yntema, S.....Saginaw

Sanilac County

Blanchard, E. W.....Deckerville
Ellis, N. J.....Croswell
Gift, W. A.....Marlette
Hart, R. K.....Croswell
Lance, Paul E.....Marlette
Learmont, H. H.....Croswell
McCrea, John W.....Marlette
McGunegle, K. T.....Sandusky
Ruhl, Frank.....Croswell
Seager, M. Cole.....Brown City
Tweedie, G. Evans.....Sandusky
Tweedie, S. Martin.....Sandusky
Webster, John C.....Marlette

St. Clair County

Armsbury, A. B.....Marine City
Attridge, J. A.....(L) Port Huron
Banting, K. C.....Port Huron
Battley, J. C. Sinclair.....Port Huron
Beck, Frank K.....Port Huron
Beer, Joseph F.....St. Clair
Benjamin, Clayton C.....Port Huron
Biggar, R. J.....Port Huron
Borden, C. L.....Port Huron
Boughner, W. H.....Algonac
Bovee, M. E.....Port Huron
Bowden, W. S.....Marine City
Brush, Howard O.....Port Huron
Burley, Jacob H.....Port Huron
Carey, Lewis H.....Port Huron
Clyne, B. C.....Yale
Cooper, T. H.....Port Huron
De Gurse, T. E.....Marine City
Fitzgerald, E. W.....Port Huron
Hall, W. E. B.....Port Huron
Hazeldine, Herbert J.....Port Huron
Hoyt, Charles M.....Port Huron
Kesl, Geo. Matthew.....Port Huron
Kirker, F. O.....St. Clair
Lauridsen, James.....Port Huron
LeGalley, K. B.....Port Huron
Licker, R. R.....Port Huron
Love, James M.....Port Huron
Ludwig, Claude A.....Port Huron
Ludwig, F. E.....Port Huron
Martin, C. S.....Port Huron
McColl, D. J.....(E) Port Huron
MacPherson, C. A.....St. Clair
Meredith, E. W.....Port Huron
Novak, Walter S.....Port Huron
Patterson, D. Webster.....Port Huron
Pollock, Donald A.....Yale
Prather, Frank W.....Yale
Sanderson, Joseph L.....Port Huron
Schaefer, W. A.....Port Huron
Sites, E. C.....Port Huron
Thomas, C. F.....Port Huron
Tomsu, Glenn F.....Yale
Treadgold, Douglas.....Port Huron
Vroman, M. E.....Port Huron
Ware, John R.....Port Huron
Wass, Henry C.....St. Clair
Waters, George.....Port Huron
Wetzel, John O.....Port Huron

St. Joseph County

Berg, Lawrence A.....Sturgis
Blood, J. V.....Three Rivers
Braham, Wilbur.....Sturgis
Brunson, A. E.....Sturgis
Fiegel, S. A.....Sturgis
Fortner, R. J.....Three Rivers
Gillespie, E.....Sturgis
Hoekman, Aben.....Constantine
Holm, Arvid G.....Three Rivers
Hoyt, Howard P.....Colon
McGrath, Neill B.....Three Rivers
Miller, C. G.....Sturgis
Myer, Clifton G.....White Pigeon
Olney, H. E.....Leonidas
Parrish, Marion.....Sturgis
Pennington, H. C.....White Pigeon
Penzotti, Stanley.....Three Rivers
Porter, C. G.....Three Rivers
Raisch, Fred J.....White Pigeon
Reed, Fred R.....Three Rivers
Shaw, George D.....Mendon
Sheldon, J. P.....Sturgis
Slote, L. K.....Constantine
Springer, R. A.....Centerville
Sweetland, G. J.....Constantine
Tesar, F. J.....Centerville
Weir, Dale C.....Three Rivers
Zimont, R. D.....Constantine

Shiawassee County

Arnold, Alfred L.....Owosso
Backe, John C.....Gaylord
Bennett, George W.....Elsie
Brown, Richard J.....Owosso
Buzzard, Walter Davenport.....Chesaning
Chipman, E. M.....Owosso
Dillon, James.....Perry
Fillinger, W. B.....Ovid
Harkness, C. A.....Owosso
Hoshal, Vern L.....Durand
Hume, Arthur M.....(E) Owosso
Hume, Harold A.....Owosso
Janci, Julius.....Owosso
McKnight, E. R.....Owosso
Merz, W. L.....Owosso
Parker, W. T.....Owosso
Pochert, R. C.....Owosso
Richards, C. J.....Durand
Shalmark, J. F.....Owosso
Shepherd, W. F.....Owosso
Slagh, E. M.....Elsie
Smith, Frank W.....Owosso
Watts, Fred A.....Owosso
Weinkauf, W. F.....Corunna
Weston, C. L.....Owosso

Tuscola County

Ballard, James H.....Cass City
Barbour, Harry A.....Mayville
Bates, George.....(E) Kingston
Berman, Harry.....Millington
Cook, Raymond.....Akron
Dickerson, Willard W.....Caro
Dixon, Robert L.....Caro
Donahue, H. Theron.....Cass City
Flett, Richard O.....Millington
Gugino, Frank James.....Reese
Howlett, R. R.....Caro
Kaven, G. H.....Unionville
Merrill, Elmer H.....Caro
Morris, Frank L.....Cass City
Nigg, Herbert L.....Caro
Pelczar, Walter.....Unionville
Ruskin, D. B.....Caro
Savage, Lloyd L.....Caro
Shoemaker, J.....Vassar
Starmann, Bernard.....Cass City
Swanson, E. C.....Vassar
Von Renner, Otto.....Vassar

Van Buren County

Boothby, Carl F.....Lawrence
Boothby, F. M.....Lawrence
Boothby, Paul R.....Lawrence
Bope, William P.....(E) Decatur
Buckborough, M. W.....South Haven
Diephuis, Bert.....South Haven
French, Merle R.....Paw Paw
Gano, Avison.....Bangor
Giffen, John R.....(E) Bangor
Greenman, Newton H.....Decatur
Hoyt, W. F.....(E) Paw Paw
Itzen, J. F.....South Haven
Maxwell, J. Charles.....(E) Paw Paw
McFadden, R. I.....Bloomingdale
Penoyar, C. L.....South Haven
Ralyea, John R.....Paw Paw
Roberts, M. S.....South Haven
Spalding, R. W.....Gobles
Steele, Arthur H.....Paw Paw
Ten Houton, Charles.....Paw Paw
Terwilliger, Edwin.....South Haven
Urist, Martin J.....South Haven
Young, William R.....Lawton

Washtenaw County

Alexander, John.....Ann Arbor
Allen, Arthur W.....(M) Ann Arbor
Asher, Wm. M.....(M) Ann Arbor
Badgley, Carl E.....Ann Arbor
Barker, Paul.....Ann Arbor
Barnwell, John B.....Washington, D. C.
Barry, George R.....(M) Ann Arbor
Barss, Harold D.....Ypsilanti
Barss, William A.....Ypsilanti
Bass, Thomas J.....Ypsilanti
Bassett, Robert C.....Ann Arbor
Bassow, Paul H.....Ann Arbor
Bates, Wm. H.....Cottonwood, Ariz.
Bauer, Jere M.....Ann Arbor
Baugh, R. H.....Ypsilanti
Beebe, Hugh M.....Ann Arbor
Beierwaltes, Wm. H.....Ann Arbor
Bell, Margaret.....Ann Arbor
Belser, Walter.....Ann Arbor
Benz, Carl A.....Ann Arbor
Berry, Robert E. L.....(M) Ann Arbor
Bethel, Frank Hartstuff.....Ann Arbor
Bohne, A. Waite.....Ann Arbor
Brace, William M.....Ann Arbor
Britton, H. B.....Ypsilanti
Brown, Philip N.....Ypsilanti
Brownlee, Wm. M.....(M) Ann Arbor
Burkett, Howard M.....Ann Arbor
Buscaglia, C. J.....Ypsilanti
Buxton, Robert W.....Ann Arbor
Byrn, Robert W.....(M) Ann Arbor
Camp, Carl Dudley.....Ann Arbor
Campbell, Kenneth N.....Ann Arbor
Cawley, Edward P.....Ann Arbor
Chrest, Clarence P.....(M) Ann Arbor
Clarke, Robert B.....Ann Arbor
Clements, Glenn T.....Ann Arbor
Clyde, Ensign E.....Plymouth
Coller, Frederick A.....Ann Arbor
Collins, James I.....(M) Ann Arbor
Compere, Dolphus E.....(M) Ann Arbor
Conn, Jerome W.....Ann Arbor
Cooper, Donald R...(M) Pittsfield Village
Coxon, A. Wm.....Ann Arbor
Crook, Clarence E.....Ann Arbor
Cummings, H. H.....Ann Arbor
Curtis, Arthur C.....Ann Arbor
Dalton, Arthur M.....(M) Ann Arbor
DeJong, Russell.....Ann Arbor
DeTar, John S.....Milan
DeWeese, Marion S.....(M) Ann Arbor
Dingman, Reed O.....Ann Arbor
Dolfin, W. E.....Ann Arbor
Donaldson, S. W.....Ann Arbor
Donovan, Eugene T.....(M) Ypsilanti
Drolett, Donald J.....(M) Ann Arbor
Duff, Ivan F.....(M) Ann Arbor
Edward, Aaron R.....Pittsfield Village
Engelke, Otto K.....Ann Arbor
Everett, Meldon.....Ann Arbor
Falls, Harold F.....Ann Arbor
Fink, George C.....Ann Arbor
Fish, Robert G.....(M) Ann Arbor
Forsythe, Warren E.....Ann Arbor
Fralick, F. Bruce.....Ann Arbor
Francis, Thomas, Jr.....Ann Arbor
Frost, Lyle W.....Ypsilanti
Frye, Carl H.....Ann Arbor
Fulton, John K.....(M) Ann Arbor
Furstenberg, Albert C.....Ann Arbor
Ganzhorn, Edwin.....Ann Arbor
Gates, John L.....Ann Arbor
Gates, Neil A., Jr.....Ann Arbor
Goldman, Abe A.....(M) Ann Arbor
Gordon, Devitt L.....(M) Ann Arbor
Gotz, Alexander.....(M) Ann Arbor
Grawn, Frank A.....Ypsilanti
Greenway, Guerdon D.....Ypsilanti
Griep, Arthur H.....(M) Ann Arbor
Gulick, Arthur E.....(M) Ann Arbor
Gustafson, Jack R.....(M) Pittsfield Village
Haas, Reynold L.....Ann Arbor
Hagerman, George W.....Ann Arbor
Haight, Cameron.....Ann Arbor
Hall, Winston C.....(M) Ann Arbor
Hammond, W. W.....Plymouth
Handorf, Heinrich Hugo.....Northville
Hannum, M. R.....Milan
Harris, Bradley M.....Ypsilanti
Harris, Scott T.....Ypsilanti
Hastings, Warren C.....Ann Arbor
Henderson, John W.....Ann Arbor
Henry, L. Dell.....Ann Arbor
Himler, Leonard E.....Ann Arbor
Hinerman, Dorin L.....Ann Arbor
Hodges, Fred J.....Ann Arbor
Holt, John F.....Ann Arbor
Hoobler, Sibley W.....Ann Arbor
House, Frederic B.....Ann Arbor
Howard, S. C.....Ann Arbor
Hunsberger, Walter G.....(M) Ann Arbor
Hunt, Robert E.....Ann Arbor
Ideson, Robert S.....Ann Arbor
Jackson, Raymond S.....(M) Ann Arbor
Jimenez, Buenaventura.....Ann Arbor
Johnston, Franklin D.....Ann Arbor
Jones, A. Curtis, Jr.....(M) Ann Arbor
Juracsek, Valeria R.....Ann Arbor
Kahn, Edgar A.....Ann Arbor
Kambly, Arnold H.....(M) Ann Arbor
Keeffe, Eugene J.....(M) Ann Arbor
Keene, Clifford H.....Ann Arbor
Kemper, J. W.....Ann Arbor
Kert, Morley J.....Los Angeles, Calif.
Killins, Charles G.....Grosse Pointe
King, Walter G.....(M) Ann Arbor
Knoll, Leo A.....Ann Arbor
La Fever, Sidney L.....Ann Arbor
Lampe, Isadore.....Ann Arbor
Law, John L.....(M) Ann Arbor
Levin, Manuel.....Ann Arbor
Lichty, Dorman E.....Ann Arbor
Locklin, W. Kaye.....(M) Ann Arbor
Lowell, Vivion F.....Ypsilanti
Lusk, Harry A.....(M) Ypsilanti
MacIntyre, Robert S.....Ann Arbor
Mahon, Ralph D.....(M) Ann Arbor
Malcolm, Karl D.....Ann Arbor
Marshall, Mark.....Ann Arbor
Martin, Donald W.....Ypsilanti
Mason, James T.....(M) Ann Arbor
Maxwell, James H.....Ann Arbor
McCotter, Rollo E.....Ann Arbor
McEachern, Thomas H.....Ann Arbor
McNicholas, John R.....(M) Ann Arbor
Mehl, Omar C.....Ann Arbor
Meyers, Muriel C.....Ann Arbor
Milford, Albert F.....Ypsilanti
Miller, Harold.....Saline
Miller, Norman F.....Ann Arbor
Muehlig, George F.....Ann Arbor
Musselman, M. M.....(M) Pittsfield Village
Myers, Dean W.....Ann Arbor
Nesbir, Reed M.....Ann Arbor
Newton, Charles W., Jr.....Ann Arbor
Nickel, Kenneth C.....Ypsilanti
O'Connor, Sylvester J.....(M) Ann Arbor
Oliphant, L. W.....Ann Arbor
Parnall, Christopher G.....Ann Arbor
Patterson, Ralph M.....Ann Arbor
Payne, Beverly C.....(M) Ann Arbor
Peet, Max.....Ann Arbor
Pollard, H. M.....Ann Arbor
Pommerening, Robert A.....Ann Arbor
Potter, Marcia.....Ypsilanti
Poznak, Leonard A.....Ann Arbor
Price, Helen F.....Ann Arbor
Prout, Gordon J.....Saline
Quilligan, J. J.....Ann Arbor
Ransom, Henry.....Ann Arbor
Raphael, Theophile.....Ann Arbor
Ratliff, Rigdon K.....Ann Arbor
Reiff, William H.....(M) Ann Arbor
Riecker, H. H.....Ann Arbor
Riggs, Harold W.....Ann Arbor
Robinson, William D.....Ann Arbor
Ross, C. Howard.....Ann Arbor
Sayre, George S.....Ypsilanti
Schoch, Henry K., Jr.....(M) Ann Arbor
Schumacker, W. E.....Ann Arbor
Scovill, H. A.....Ypsilanti
Seevers, Maurice H.....Ann Arbor
Seime, Reuben I.....Ypsilanti
Shapiro, Hyman D.....(M) Ann Arbor
Sheldon, John M.....Ann Arbor
Sibbald, Malcolm L.....Chelsea
Sink, Emory W.....Ann Arbor
Slenger, Walworth R.....Ann Arbor
Smalley, Marianna.....Ann Arbor
Smith, Eleanor.....Ann Arbor
Snow, Glenadine.....Ypsilanti
Spears, Clarence W.....Ypsilanti
Stewart, Wayne H.....(M) Ann Arbor
Strayer, John W.....(M) Ann Arbor
Struthers, J. N. P.....Ann Arbor
Sturgis, Cyrus C.....Ann Arbor
Sundwall, John.....Ann Arbor
Swank, Helen S.....Ann Arbor
Sweet, Robert B.....(M) Ann Arbor
Taylor, George D.....(M) Ann Arbor
Teed, Reed Wallace.....Ann Arbor
Thieme, E. Thurston.....Ann Arbor
Thompson, James B.....Ann Arbor
Thomson, Daniel C.....(M) Ann Arbor
Tompsett, Arthur C., Jr...(M) Ann Arbor
Towsley, Harry A.....Ann Arbor
Ulmer, Arthur H.....(M) East Ann Arbor
Waggoner, R. W.....Ann Arbor
Waldron, Alexander M.....Ann Arbor
Washburne, Charles L.....Ann Arbor
Watson, Ernest Hamilton.....Ann Arbor
Weeks, William F.....(M) Ann Arbor
Weller, Keith E.....(M) Ann Arbor
Wertenberger, M. D.....Ann Arbor
Wessinger, J. A.....(E) Ann Arbor
Westerberg, Martha R.....Ann Arbor
Westover, Charles J.....Plymouth
Wiesinger, Warren E.....(M) Ann Arbor
Wile, Udo J.....Ann Arbor
Wilkinson, Chas. F.....Ann Arbor
William Howard R.....Ann Arbor
Williamson, F. B.....Ypsilanti
Wilson, Frank N.....Ann Arbor
Wilson, James LeRoy.....Ann Arbor
Wisdom, Inez.....Ann Arbor
Wollum, Arnold.....(M) Ann Arbor
Woods, J. J.....Ypsilanti
Worth, Melissa H.....Ypsilanti
Wright, Edwin M.....(M) Ann Arbor
Wright, Walter J.....Ypsilanti
Wylie, Wm. C.....Dexter
Yared, Jerome A.....(M) Ann Arbor
Yoder, O. R.....Ypsilanti
Zatzkin, Herbert R.....(M) Ann Arbor
Zerbi, Victor M.....Willow Run Village

Wayne County

Aaron, Charles D.....(E) Detroit
Abbott, H. L.....Detroit
Abbott, William E.....Detroit
Abruzzo, Anthony M.....Eloise
Adamian, Gerald.....Detroit
Adams, James Robert.....Dearborn
Adelson, Sidney L.....Detroit
Adler, Sidney.....Detroit
Agnew, George H.....Detroit
Akroyd, Cecil.....Detroit
Albrecht, Herman F.....Detroit
Alderman, R. F.....Detroit
Aldrich, E. Gordon.....Detroit
Aldrich, Napier S.....Detroit
Alexander, Eugene James.....Detroit
Alford, E. S.....Belleville
Allen, John V.....Lincoln Park
Alles, Russell W.....Detroit
Allison, Frank B.....Detroit
Allison, Herbert C.....Grosse Pointe Farms
Alper, Louis.....Detroit

Alpiner, Sam.....Detroit
Altman, Raphael.....Detroit
Altshuler, Abraham M.....Detroit
Altshuler, Ira M.....Detroit
Altshuler, Samuel.....(M) Battle Creek
Amolsch, Arthur L.....Detroit
Amos, Thomas G.....Detroit
Anderson, Bruce.....(L) Detroit
Anderson, Charles P.....Eloise
Anderson, Gordon H.....Dearborn
Anderson, J. O.....Detroit
Anderson, Raymond T.....Detroit
Anderson, Walter L.....Detroit
Anderson, Walter T.....Detroit
Anderson, William H.....(M) Ewen
Andries, George H., Jr.....Detroit
Andries, Joseph H.....(E) Detroit
Andries, Raymond C.....Detroit
Ankley, J. W.....Detroit
Annessa, Dommenico M.....Detroit
Anslow, Robert E.....Detroit
Appel, Phillip R.....Detroit
Appelman, H. B.....Detroit
Archambault, Henry.....Detroit
Arehart, Burke W.....Detroit
Arent, John G.....Detroit
Armstrong, Arthur G.....Detroit
Arnold, Effie.....Detroit
Aronstam, Noah E.....(L) Detroit
Arrington, Robyn J.....Detroit
Ascher, Meyer S.....Detroit
Ashe, Stilson R.....Detroit
Ashley, L. Byron.....Detroit
Ashton, F. B.....(L) Highland Park
Asselin, Regis F.....Detroit
Atchison, Russell M.....Northville
Athay, Roland M.....Eloise
Atler, Lawrence R.....Detroit
Atler, Leroy L.....Detroit
Auble, Max E.....Detroit
August, Harry E.....Detroit
Auld, Douglas V.....Detroit
Avrin, Ira.....Detroit
Axelson, A. U.....Detroit

Babcock, Kenneth B.....Detroit
Babcock, L. K.....Detroit
Babcock, Myra E.....Detroit
Babcock, W. W.....Detroit
Bach, Walter F.....Detroit
Bachman, Morris E.....Detroit
Bacon, Vinton A.....Detroit
Bader, Benjamin H.....Detroit
Baer, George J.....Detroit
Baer, Raymond B.....Detroit
Baeff, Michael A.....Detroit
Bagley, Harry E.....Dearborn
Bailey, Carl C.....Detroit
Bailey, Don A.....Detroit
Bailey, John H.....Detroit
Bailey, Louis J.....Detroit
Baker, Clarence.....Detroit
Baker, Howard A.....Detroit
Bakst, Joseph.....Detroit
Balaga, F. T.....Detroit
Balberor, Harry.....Detroit
Balcerski, Matthew A.....Detroit
Ballard, Charles S.....Detroit
Balser, Charles W.....Detroit
Baltz, James I.....Detroit
Baranowski, A. W.....Detroit
Barland, Oscar L.....Detroit
Barnes, Donald J.....Detroit
Barnett, Edwin D.....Detroit
Barnett, Morton.....Detroit
Barnett, Saul E.....Detroit
Barone, Charles J.....Highland Park
Barrett, Clarence D.....Dearborn
Barrett, Wyman D.....Detroit
Barron, William H.....Detroit
Bartemeier, Leo H.....Detroit
Barton, J. R.....Detroit
Bates, Gaylord S.....Dearborn
Bauer, Benedict J.....Detroit
Bauer, A. Robert.....Detroit
Bauer, Lester Eugene.....Detroit
Baumer, Moe.....Detroit
Baumgarten, Elden C.....Detroit
Bayles, John G.....Detroit
Beach, Watson.....Detroit
Beam, A. Duane.....Grosse Pointe
Beamer, George D.....Dearborn
Beaton, Colin.....Detroit
Beattie, Robert.....(L) Detroit
Beaver, Donald C.....Detroit
Beck, Eva F.....Eloise
Becker, Abraham.....Detroit
Becker, Joseph Wm.....Detroit
Becklein, C. L.....Detroit
Beckwith, Carl C.....Detroit
Beckwitt, M. C.....Detroit
Bedell, A.....Detroit
Beeuwkes, L. E.....Dearborn
Behn, Claud W.....Detroit
Beigler, Sydney K.....Detroit
Beitman, Max R.....Detroit
Belanger, Henri.....(E) River Rouge
Belanger, Wm. George.....Detroit
Belisle, John A.....Eloise
Bell, J. Kenner.....Detroit
Bell, William.....Detroit
Benjamin, Wm. O.....Detroit
Bennett, Germany E.....Detroit
Bennett, Harry B.....Detroit
Bennett, Sanford A.....Detroit
Bennett, Zina B.....Detroit
Benson, C. D.....Detroit
Benson, Davis A.....Detroit
Benson, Virginia.....Detroit
Bentley, Frederick E.....Plymouth
Bentley, Neil I.....Detroit
Berent, Morris S.....Detroit
Berge, Clarence A.....Detroit
Bergman, Murray S.....Detroit
Bergo, Howard L.....Detroit
Berke, Sydney S.....Detroit
Berkey, Wm. E.....Detroit
Berkman, Ruth.....Detroit
Berlien, Ivan C.....Detroit
Berman, Lawrence.....Detroit
Berman, Robert.....Detroit
Berman, Sidney.....Detroit
Bermucci, Robert J.....Detroit
Bernard, Walter G.....Detroit
Bernbaum, Bernard.....Detroit
Bernstein, Albert E.....Detroit
Bernstein, Samuel S.....Detroit
Berry, Joseph E.....Detroit
Besancon, J. H.....Detroit
Best, T. H. Edward.....Detroit
Bicknell, Edgar A.....Detroit
Bicknell, Frank B.....Detroit
Birch, John R.....Detroit
Birmingham, John R.....Detroit
Birkelo, Carl C.....Detroit
Birndorf, Leonard.....Detroit
Bittker, I. Irving.....Detroit
Black, Perry S.....Detroit
Blaha, Vernon B.....Detroit
Blain, Alexander W.....Detroit
Blain, Alexander III.....Detroit
Blain, James H., Jr.,.....Detroit
Blaine, Max.....Detroit
Blair, K. E.....Detroit
Blanchet, Alred D.....Detroit
Blashill, James B.....Detroit
Bleier, Alfred.....Detroit
Bleier, Joseph.....Detroit
Bloch, Abraham.....Detroit
Blodgett, Wm. E.....(L) Detroit
Blodgett, William H.....Detroit
Bloom, Arthur R.....Detroit
Blumenthal, Franz L.....Detroit
Boccaccio, John.....Detroit
Boccia, James J.....Detroit
Boddie, Arthur W.....Detroit
Boddie, Lewis F.....Detroit
Boell, Arthur F.....Detroit
Bogue, Robert E.....Detroit
Bogusz, Ladislaus.....Eloise
Bohn, Z. Stephen.....Detroit
Boileau, T. I.....Detroit
Bolstad, Donald S.....Detroit
Bookmyer, R. H.....Detroit
Bookstein, Abraham M.....Detroit
Bornstein, Sidney.....Detroit
Bott, Edmund T.....Wyandotte
Botvinick, Isadore.....Detroit
Boutrous, Thomas A.....Detroit
Bovill, E. G.....Detroit
Bower, Franklin T.....Detroit
Bowers, Leo J.....Detroit
Brachman, D. S.....Detroit
Bracken, Andrew H.....Dearborn
Bradley, George.....Detroit
Bradshaw, Wm. H.....Detroit
Brady, Herbert A.....River Rouge
Braitman, Louis.....Detroit
Braley, W. N.....Detroit
Bramigk, Fritz W.....Detroit
Brando, Russell G.....Detroit
Brandt, Edward L.....Detroit
Braun, Lionel.....Detroit
Braverman, Morris.....Detroit
Breitenbecher, Edw. R.....Detroit
Brekke, Viola G.....Detroit
Bremer, Wm. M.....Detroit
Brengle, Deane R.....Detroit
Breon, Guy L.....Detroit
Briegel, Walter A.....Detroit
Brines, O. A.....Detroit
Bringard, Elmer L.....Detroit
Brisbois, Harold J.....Plymouth
Brisson, Joseph.....Detroit
Broadman, Sylvan.....Detroit
Bromme, William.....Detroit
Bronson, Wm. W.....Detroit
Brooks, A. L.....Flint
Brooks, Clark D.....Detroit
Brooks, Charles W.....Detroit
Brooks, Nathan.....Detroit
Brosius, Wm. L.....Detroit
Brough, Glen A.....Detroit
Brown, A. O.....Detroit
Brown, Carlton F.....Detroit
Brown, Charles H.....Detroit
Brown, Francis.....Detroit
Brown, Gordon T.....Detroit
Brown, Harvey F.....Detroit
Brown, Henry S.....Detroit
Brown, John R.....Detroit
Brown, Robert A.....Detroit
Brown, Samuel.....Detroit
Brown, Stanley H.....Detroit
Brown, Thomas A.....Detroit
Brownell, Paul G.....Detroit
Bruehl, Richard.....Detroit
Bruer, Edgar S.....Ecorse
Bruer, Edwin L.....Detroit
Brunk, Andrew S.....Detroit
Brunk, C. F.....Detroit
Brunke, B. B.....Detroit
Brush, Brock Edwin.....Detroit
Bryce, John D.....Detroit
Buchanan, W. Paul.....Detroit
Buck, John D.....Detroit
Budson, Daniel.....Detroit
Buesser, Frederick G.....Detroit
Buller, H. L.....Detroit
Burgess, Charles M.....Detroit
Burnstine, Julius Y.....Detroit
Burnstine, Perry P.....Detroit
Burr, George C.....Detroit
Burr, H. Leonard.....Detroit
Burroughs, R. G.....Detroit
Burrows, Howard A.....Dearborn
Burstein, Harry S.....Detroit
Burstein, I. Marvin.....Detroit
Burstein, Morris M.....Detroit
Burton, D. T.....Detroit
Burton, I. F.....Detroit
Bush, Glendon J.....Detroit
Bush, Lowell M.....Detroit
Butler, Harry J.....(L) Highland Park
Butler, J. Payne.....Detroit
Butler, L. H.....Detroit
Butler, Volney N.....Detroit
Butterworth, Herman K.....Lincoln Park
Buttrum, Edward J.....Detroit
Byers, Dudley W.....Detroit
Byington, Garner M.....Detroit

Cadieux, Henry W.....(L) Detroit
Cahalan, Joseph L.....Detroit
Caldwell, J. Ewart.....Detroit
Caldwell, George L.....Detroit
Calkins, H. N.....Detroit
Callaghan, T. T.....Detroit
Cameron, A. H.....Wyandotte
Cameron, Duncan A.....Detroit
Campau, George H.....Detroit
Campbell, Charles A.....Dearborn
Campbell, Darrell A.....Eloise
Campbell, Duncan.....Detroit
Campbell, Duncan A.....(L) Detroit
Campbell, Malcolm D.....Detroit
Campbell, Mary B.....Detroit
Candler, Clarence L.....Detroit
Canter, Allie L.....Detroit
Canter, G. E.....Detroit
Cantor, M. O.....Detroit
Capano, Oreste, A.....Pontiac
Capellari, Elmer E.....Detroit
Caputo, Joseph M.....Dearborn
Caraway, James E.....Wayne
Carbone, Louis A.....Detroit
Carey, Cornelius.....Detroit
Carleton, Lawrence H.....Detroit
Carlson, Harold W.....Detroit
Carmichael, E. K.....Detroit
Carnes, Harry E.....Detroit
Carp, Joseph.....Detroit
Carpenter, C. H.....Detroit
Carpenter, C. J.....Detroit
Carpenter, Glenn B.....Detroit
Carpenter, William S.....Detroit
Carr, J. G.....Detroit
Carroll, E. H.....Detroit
Carroll, Lona B.....Detroit
Carrick, Lee.....Detroit
Carson, Herman J.....Detroit
Carstens, Henry R.....Philadelphia, Pa.
Carter, John M.....Detroit
Carter, L. F.....Detroit
Cassidy, Wm. J.....Detroit
Castrop, C. W.....Dearborn
Catherwood, A. E.....Detroit
Caton, Dorothy.....Detroit
Caughey, E. H.....Detroit
Caumartin, Fred E.....Detroit
Cavell, Roscoe W.....Detroit
Ceresko, A. R.....Detroit

Chalat, Jacob H. ..... Detroit
Chabut, V. George ..... Northville
Chall, Henry G. ..... Detroit
Chapin, Sidney E. ..... Dearborn
Chapman, Aaron L. ..... Detroit
Chapman, Paul T. ..... Detroit
Chapnick, H. A. ..... Detroit
Charleston, R. A. ..... Detroit
Charnas, Sidney ..... Detroit
Chase, Clyde H. ..... Detroit
Chatel, Arthur N. ..... Detroit
Chesluk, H. M. ..... Detroit
Chester, W. P. ..... Detroit
Childs, George M. ..... Detroit
Chipman, W. A. ..... Detroit
Chittenden, George E. ..... Detroit
Chostner, G. C. ..... Detroit
Christensen, C. A. ..... Dearborn
Christopher, James G. ..... Detroit
Chrouch, Laurence A. ..... Detroit
Church, Aloysius ..... Detroit
Cioffari, Mario S. ..... Detroit
Ciprian, Joseph E. ..... Detroit
Clark, Benj. W. ..... (M) Detroit
Clark, Charles J. ..... Dearborn
Clark, C. M. ..... Detroit
Clark, Donald V. ..... Detroit
Clark, George E. ..... (E) Detroit
Clark, Harold E. ..... Detroit
Clark, Harry G. ..... Detroit
Clark, Harry L. ..... Detroit
Clark, Ronald E. ..... Detroit
Clarke, Norman E. ..... Detroit
Clifford, Charles H. ..... Detroit
Clifford, John E. ..... Detroit
Clifford, Thomas P. ..... Detroit
Clippert, J. C. ..... Grosse Ile
Coan, Glenn L. ..... Wyandotte
Coates, Carl Amos ..... Dearborn
Cobane, John H. ..... Detroit
Cochrane, Edgar G. ..... Detroit
Cohen, H. Herbert ..... Detroit
Cohn, Daniel E. ..... Detroit
Cohoe, Don A. ..... Detroit
Cole, Fred H. ..... Detroit
Cole, James E. ..... Detroit
Cole, Wyman C. C. ..... Detroit
Coleman, Margarete W. ..... Detroit
Coleman, William G. ..... Redford
Coll, Howard R. ..... Detroit
Collins, James D. ..... Detroit
Colvin, Leslie T. ..... Detroit
Colyer, Raymond G. ..... Detroit
Comfort, Milton D. ..... Flat Rock
Comstock, Lawrence ..... Trenton
Condon, Stanley ..... Detroit
Conley, L. C. M. ..... Detroit
Conn, Harold ..... Detroit
Connelly, Richard C. ..... Detroit
Conner, Edward D. ..... Detroit
Connolly, Frank ..... Detroit
Connolly, John P. ..... Detroit
Connolly, Paul J. ..... Detroit
Connors, J. J. ..... Detroit
Conrad, E. R. ..... Detroit
Constable, Canute G. ..... Detroit
Cook, James C. ..... Detroit
Cooksey, Warren B. ..... Detroit
Coolidge, Maria Belle (L) .. Grosse Pt. Pk.
Cooper, B. J. ..... Detroit
Cooper, E. L. ..... Detroit
Cooper, James B. ..... Detroit
Cooper, Ralph R. ..... Detroit
Corbeille, Catherine ..... Detroit
Coseglia, Robert P. ..... Detroit
Cosgrove, Wm. J. ..... Detroit
Costello, Russell T. ..... Detroit
Cotruro, L.D. ..... Detroit
Cotton, S. O. ..... Detroit
Coulter, Wm. J. ..... Detroit
Courville, Charles J. ..... Detroit
Cowan, Wilfrid ..... Detroit
Cowen, Leon B. ..... Detroit
Cowen, Robert L. ..... Detroit
Coyne, Douglas R. ..... Detroit
Crane, Lagdon T. ..... Detroit
Crane, Thomas P. ..... Dearborn
Cree, Walter J. ..... (E) Detroit
Crews, Thomas H. ..... Detroit
Croll, L. J. ..... Detroit
Croll, Maurice ..... Detroit
Crook, Charles L. ..... Highland Park
Cross, Harold E. ..... Detroit
Crossen, Henry F. ..... Detroit
Croushore, J. E. ..... Detroit
Cruikshank, Alexander ..... (E) Detroit
Culp, Ormond ..... Detroit
Curhan, Joseph H. ..... Detroit
Curry, F. S. ..... Detroit
Curtis, Frank E. ..... Detroit
Curtiss, William P. ..... Detroit
Cushing, Russell G. ..... Detroit
Cushman, H. P. ..... Detroit
Cusick, Paul L. ..... Detroit

Dale, Esther H. ..... Detroit
Dale, Mark ..... Detroit
Danforth, James C., Jr. ..... Grosse Pointe
Danforth, J. C. ..... Detroit
Danforth, Mortimer E. ..... Detroit
Daniels, L. E. ..... Detroit
Darling, Milton A. ..... Detroit
Darpin, Peter H. ..... Detroit
Dart, Edward E. ..... Detroit
Davidson, Harry O. ..... Detroit
Davies, Thomas S. ..... Grosse Pointe
Davies, Windsor S. ..... Detroit
Davis, Egbert F. ..... (L) Detroit
Davis, George H. ..... (M) Detroit
Dawson, F. E. ..... Detroit
Dawson, Ralph ..... Detroit
Dawson, W. A. ..... Inkster
Day, A. Jackson ..... Detroit
Day, J. Claude ..... Detroit
Deering, Robert J. ..... River Rouge
Defever, Cyril R. ..... Detroit
Defnet, Wm. A. ..... Detroit
DeJongh, Edwin ..... Detroit
Delaney, James ..... Detroit
Demaray, John F. ..... Detroit
Dempster, James H. ..... (L) Detroit
De Nike, A. James ..... Detroit
Denis, George M. ..... Detroit
Denison, Louis L. ..... Detroit
DePonio, Sylvester A. ..... Detroit
Derby, Arthur P. ..... Detroit
Deresz, Alphonse ..... Detroit
Derleth, Paul E. ..... Detroit
De Spelder, Ray E. ..... Detroit
De Tomasi, Rome Q. ..... Detroit
Dibble, Harry F. ..... Detroit
Dickson, B. R. ..... Detroit
Dickson, Elias L. ..... Detroit
Diebel, Nelson W. ..... Detroit
Dietzel, H. O. ..... Detroit
Dill, Hugh L. ..... Detroit
Dill, J. Lewis ..... Detroit
Di Loreto, Panfilo C. ..... Detroit
Dinnen, William ..... Detroit
Dittmer, Edwin ..... Detroit
Dixon, Fred W. ..... Dearborn
Dixon, Ray S. ..... Detroit
Dixon, Robert K. ..... Detroit
Dodds, John C. ..... Detroit
Dodenhoff, C. F. ..... Detroit
Dodrill, F. D. ..... Detroit
Doerr, Louis E., Jr. ..... Detroit
Dolega, Stanley F. ..... Detroit
Dolman, E. Nesbitt ..... Detroit
Domzalski, C. A. ..... Detroit
Donald, Douglas ..... Detroit
Donovan, Daniel R., Jr. ..... Detroit
Donovan, Richard S. ..... Detroit
Dorniak, Ben P. ..... Detroit
Dorsey, John M. ..... Highland Park
Doty, Chester A. ..... Detroit
Doub, Howard P. ..... Detroit
Douglas, Bruce H. ..... Detroit
Douglas, Clair L. ..... Detroit
Dovitz, Benjamin W. ..... Detroit
Dow, Roy E. ..... Detroit
Dowdle, Edward ..... Detroit
Downer, Ira G. ..... Detroit
Doyle, George H. ..... Detroit
Drake, Ellet H. ..... Detroit
Drake, James J. ..... Detroit
Draves, Edward F. ..... Detroit
Drews, Robert S. ..... Detroit
Drinkhaus, Harold I. ..... Detroit
Droock, Victor ..... Detroit
Dubin, Joseph J. ..... Detroit
Dubnove, Aaron ..... Detroit
Du Bois, Paul W. ..... Detroit
Dubpernell, Karl ..... (E) Detroit
Dubpernell, Martin S. ..... Detroit
Dudek, John J. ..... Detroit
Dundas, Edw. M. ..... Detroit
Dunlap, Henry A. ..... Detroit
Dunlap, Samson F. ..... Detroit
Dunn, Cornelius E. ..... Detroit
Durocher, Edmund J. ..... Ecorse
Dwaihy, Paul ..... Detroit
Dwyer, Francis ..... Detroit
Dziuba, John F. ..... Detroit

Eades, Charles C. ..... Detroit
Eadie, Gordon A. ..... Detroit
Eakins, Frederick J. ..... Dearborn
Eaton, Crosby D. ..... Detroit
Eder, Joseph R. ..... Detroit
Eder, Samuel J. ..... Detroit
Edgar, Irving I. ..... Detroit
Edgar, Russell G. ..... Detroit
Edmonds, W. N. ..... Detroit
Edmondson, Robert B. ..... Detroit
Edwards, Gilbert L. ..... Detroit
Edwards, J. W. ..... Detroit
Eisman, Clarence H. ..... Detroit
Eldredge, Edward F. ..... Detroit
Ellias, Elmer P. ..... Dearborn

Elliott, Wm. G. ..... Detroit
Elman, Meyer J. ..... Detroit
Elvidge, Robert J. ..... Detroit
Emmert, Herman C. ..... (L) Detroit
Engel, Earl H. ..... Wyandotte
English, Leo V. ..... Detroit
Eno, Laurel S. ..... Detroit
Ensign, Dwight C. ..... Detroit
Ensing, Osborn ..... Detroit
Epstein, S. G. ..... Detroit
Erickson, Eldon W. ..... Detroit
Erickson, Milton H. ..... Eloise
Erkfitz, Arthur W. ..... Detroit
Eschbach, Joseph W. ..... Dearborn
Estabrook, Bert U. ..... Detroit
Ettinger, Clayton J. ..... Detroit
Evans, Joseph M. ..... Detroit
Evans, Leland S. ..... Detroit
Evans, William A., Jr. ..... Detroit
Evison, Emerson ..... Detroit
Ewing, C. H. ..... Detroit
Eyres, Albert E. ..... Grosse Pointe

Fagin, Irvin D. ..... Detroit
Falick, M. L. ..... Detroit
Falk, Ira E. ..... Detroit
Fallis, Lawrence S. ..... Detroit
Fandrich, Theodore ..... Detroit
Farbman, Aaron A. ..... Detroit
Fauman, David H. ..... Detroit
Faunce, Sherman P. ..... Detroit
Felcyn, W. George ..... Detroit
Feld, David ..... Detroit
Feldkamp, Lee E. ..... Detroit
Feldman, Paul ..... Detroit
Feldstein, Martin Z. ..... Detroit
Fellers, Ray L. ..... Detroit
Fenech, Harold B. ..... Detroit
Fenner, Wm. G. ..... Detroit
Fenton, E. H. ..... Detroit
Fenton, Meryl M. ..... Detroit
Fenton, Russell F. ..... Detroit
Fenton, Stanley C. ..... Detroit
Ferrara, Virginia M. ..... Detroit
Ferrera, Louis V. ..... Detroit
Fettig, Carl A. ..... (L) Detroit
Finch, Alvis D. ..... Detroit
Finch, F. Sinclair ..... Detroit
Fine, Edward ..... Detroit
Finkelstein, M. B. ..... Detroit
Fischer, Frederick J. ..... Detroit
Fisher, George S. ..... Detroit
Fisher, O. O. ..... Detroit
Fisher, R. L. ..... Detroit
Fitzgerald, James M. ..... Detroit
Flaherty, H. J. ..... Detroit
Flaherty, Norman W. ..... Dearborn
Fleming, L. N. ..... Detroit
Flora, Wm. R. ..... Detroit
Flower, J. A. ..... Detroit
Fogt, Herbert E. ..... Detroit
Fogt, Robert G. ..... Detroit
Foley, Hugh S. ..... Dearborn
Foley, Joseph M. ..... Detroit
Font, Anthony J. ..... Detroit
Foote, James A. ..... Lincoln Park
Ford, George A. ..... Detroit
Ford, Sylvester ..... Detroit
Ford, Walter D. ..... Detroit
Fordell, F. S. ..... Detroit
Forrester, Alex V. ..... Detroit
Forsythe, John R. ..... Detroit
Foster, E. Bruce ..... Detroit
Foster, Daniel P. ..... Detroit
Foster, Linus J. ..... Detroit
Foster, Owen C. ..... Detroit
Foster, Wm. L. ..... Detroit
Foster, W. M. ..... Detroit
Fowler, Melvin E. ..... Detroit
Fox, Morris E. ..... Dearborn
Fraiberg, Paul L. ..... Detroit
Franjac, M. J. ..... Dearborn
Franklin, John ..... Detroit
Franzen, Nils A. ..... Detroit
Fraser, Eldred E. ..... Detroit
Frazer, Mary Margert ..... Detroit
Free, Harry W. ..... Detroit
Freedman, John ..... Detroit
Freedman, Milton ..... Detroit
Freeman, B. F. ..... Detroit
Freeman, D. K. ..... Detroit
Freeman, Mabel ..... Detroit
Freeman, Michael ..... Detroit
Freeman, Thelma ..... Detroit
Freeman, Wilmer ..... Detroit
Freid, Samuel ..... Detroit
Freier, Morton L. ..... Detroit
Fremont, Joseph C. ..... Detroit
Freund, Hugo A. ..... Detroit
Friedlaender, Alex S. ..... Detroit
Friedlaender, Sidney ..... Detroit
Friedman, David ..... Detroit
Friedman, I. H. ..... Detroit
Frothingham, George E. ..... (E) Detroit

Fruend, Henrietta.....Detroit
Fryfogle, James D.....Detroit
Fullenwider, Allan C.....Detroit
Fuller, Hugh M.....Detroit
Fulton, Wm. James.....Detroit

Gaba, Howard.....Detroit
Gabe, Sigmund.....Detroit
Gaberman, David B.....Detroit
Gaffney, J. Mitchell.....Detroit
Galantowicz, H. C.....Detroit
Galdonyi, Laslo L.....Detroit
Galdonyi, Nicholas.....Detroit
Galerneau, D. B.....Center Line
Gamble, Parker B.....Detroit
Gannan, Arthur M.....Detroit
Ganschow, John H.....Detroit
Gardner, Lawrence.....Detroit
Gariepy, Louis J.....Detroit
Gaston, Herbert B.....Detroit
Gates, Nathaniel H.....Detroit
Gaynor, Alex.....Detroit
Gehring, Harold W.....Detroit
Geib, Ledru O.....Detroit
Geitz, Wm. A.....Detroit
Gelbach, Philip D.....Detroit
Gellert, I. S.....Detroit
Gemeroy, J. C.....Detroit
Gerondale, Edmond J.....Detroit
Giese, Fred W.....Detroit
Gigante, Nicola.....Detroit
Gilbert, Harold R.....Wyandotte
Gillespie, Stephen M.....Dearborn
Gillman, R. W.....(E) Detroit
Ginsberg, Harold I.....Detroit
Gitlin, Charles.....Detroit
Gitlin, Julius R.....Detroit
Gittins, Perry C.....Detroit
Glasgow, Gordon K.....Detroit
Glassman, Samuel.....Detroit
Glazer, Walter S.....Detroit
Glees, J. L.....Grosse Pointe Farms
Glemet, Raymond B.....Detroit
Glowacki, B. F.....Detroit
Gmeiner, Clarence C.....Detroit
Goerke, Elmer A.....Romulus
Goetz, Angus G.....Detroit
Goins, Wm. F.....Detroit
Goldberg, Arthur.....Detroit
Goldberg, Harry H.....Detroit
Goldberg, Nathan.....Detroit
Goldin, M. I.....Eloise
Goldman, Aubrey.....Detroit
Goldman, Perry.....Detroit
Goldsmith, Joseph D.....Detroit
Goldstone, R. R.....Detroit
Gollman, Maurice D.....Detroit
Gonne, Wm. S.....Detroit
Goodrich, B. E.....Detroit
Gordon, John W.....(R) Detroit
Gordon, William H.....Detroit
Gorelick, Martin J.....Dearborn
Gorning, Raymond P.....Detroit
Goryl, Stephen V.....Detroit
Gostine, Edmond.....Detroit
Gottschalk, Fred W.....Detroit
Gould, S. E.....Eloise
Gourley, E. V.....Detroit
Goux, R. S.....Detroit
Grace, J. M.....Detroit
Gradolph, Paul L.....(M) Detroit
Graff, J. M.....Detroit
Graham, Julius A.....Detroit
Grain, Gerald O.....Detroit
Grajewski, Leo E.....Detroit
Gramley, Wm.....Detroit
Granger, Francis L.....Detroit
Gratton, Henri L.....Detroit
Gravelle, Lawrence J.....Detroit
Gray, Jacques Pierce.....Detroit
Greek, Louis M.....Detroit
Green, Ellis R.....Detroit
Green, Lewis.....Detroit
Green, Louis M.....Detroit
Green, Nelson W.....Detroit
Green, Simpson W.....Detroit
Greenberg, Jack R.....Detroit
Greenberg, Julius J.....Detroit
Greenberg, Morris Z.....Detroit
Greene, John B.....Detroit
Greenidge, Robert.....Detroit
Greenlee, Wm. Tate.....Detroit
Greiner, Bert A.....Detroit
Grekin, John N.....Detroit
Grekin, Samuel L.....Detroit
Griffith, Arthur J.....Detroit
Griffiths, Sidney.....Detroit
Grillo, S. Phillip.....Belleville
Grimaldi, G. J.....Detroit
Grinstein, Alexander.....Detroit
Grob, Otto.....Detroit
Grossman, Sol.....Detroit
Gruber, T. K.....Eloise
Guerrero, Jose.....Detroit
Guimaraes, A. S.....Dearborn

Gullickson, Miles J.....Eloise
Gurdjian, E. S.....Detroit
Gurskis, Eugenia.....Detroit
Gutow, Benjamin R.....Detroit
Gutterman, Meyer A.....Detroit

Haefele, Leslie P.....Garden City
Haig, D. B.....Detroit
Haking, Leonard.....Detroit
Hale, Arthur S.....Detroit
Hall, E. Walter.....Detroit
Hall, James A. J.....Detroit
Hall, Ralph E.....Detroit
Hall, Robert J.....Detroit
Hallen, Leonard.....Detroit
Haluska, Joseph A.....Detroit
H'Amada, Norman K.....Detroit
Hamilton, Norman C.....Detroit
Hamilton, William.....Detroit
Hamilton, Wm. F.....(L) Detroit
Hammer, Edwin J.....Detroit
Hammer, Howard J. San Francisco, Cal.
Hammond, A. E.....Detroit
Hammond, James L.....Inkster
Hand, Fordus V.....Detroit
Hanna, Carl.....Detroit
Hanna, E. Howard.....Detroit
Hansen, Frederick E.....Detroit
Hanser, Joshua.....(L) Detroit
Hanson, Frederick N.....Wayne
Hanson, Joseph.....Detroit
Hardstaff, R. John.....Detroit
Hardy, George C.....Detroit
Harelik, E. W.....Detroit
Harkaway, Roman.....Detroit
Harley, Garth H.....Detroit
Harley, Louis M.....Detroit
Harm, W. B.....Detroit
Harper, Jesse T.....Detroit
Harrell, Voss.....Reno, Nev.
Harris, Harold H.....Detroit
Harris, Ivor D.....Detroit
Harrison, Hugh.....(E) Detroit
Harrison, Wesley, Jr.....Detroit
Hart, Charles E.....Detroit
Hart, J. Clarence.....Detroit
Hartkop, Henry H.....Detroit
Hartman, Frank W.....Detroit
Hartmann, W. B.....Detroit
Hartzell, John B.....Detroit
Hasley, Clyde K.....Detroit
Hasley, Daniel E.....Detroit
Hassig, Walter W.....Detroit
Hastings, Orville J.....Detroit
Hause, Glen E.....Detroit
Hauser, I. Jerome.....Detroit
Hauser, John E.....Detroit
Hauser, Maurice.....Detroit
Havers, Howard.....Detroit
Hawkins, James W.....Detroit
Hayes, Joseph D.....Detroit
Heath, Leonard P.....Detroit
Heavner, L. E.....Detroit
Hecht, Manes.....Detroit
Hedges, Frank W.....Detroit
Hedrick, Donald W.....Detroit
Heenan, T. H.....Detroit
Heideman, Louis.....Detroit
Heldt, Thomas J.....Detroit
Hendelman, Manuel H.....Detroit
Henderson, A. B.....Detroit
Henderson, Allison B.....Detroit
Henderson, Harold.....Detroit
Henderson, James L.....Detroit
Henderson, Leslie T.....Detroit
Henderson, Wm. E.....Detroit
Hendricks, Frank R.....Detroit
Henig, Fred.....Detroit
Henrich, L. E.....Detroit
Herkimer, Dan R.....Lincoln Park
Herrold, Rose E.....Detroit
Herschelmann, Roy F.....Detroit
Hewitt, Leland V.....Detroit
Hewitt, Robert S.....Dearborn
Heyner, Stanley A.....Detroit
Hickey, Joseph.....Detroit
Hicks, Fred G.....Dearborn
Hiebert, J. M.....Detroit
Higbee, Arthur L.....Detroit
Hileman, Lee.....Ecorse
Hillenbrand, Alfred E.....Grosse Pointe
Hiller, Glenn I.....Detroit
Hilton, Wm. E.....Detroit
Hinko, Edward N.....Eloise
Hirschfield, Alexander H.....Detroit
Hirschman, L. J.....Detroit
Hochman, Morton M.....Detroit
Hodgkinson, C. P.....Detroit
Hodges, Roy W.....Detroit
Hodoski, Frank J.....Detroit
Hoenig, Andrew L.....Mancelona
Hoffman, E. S.....Detroit
Hoffman, Edward A.....Detroit
Hoffman, Harry Y.....Detroit
Hoffman, Henry A.....Detroit

Hoffman, Martin H.....Detroit
Holcomb, August A.....Northville
Holcomb, Clayton E.....Detroit
Hollander, A. J.....Detroit
Hollis, Henry B.....Detroit
Holman, Herbert H.....Detroit
Holmes, Alfred W.....Detroit
Holt, Henry T.....Detroit
Honhart, Fred L.....Detroit
Honor, Wm. H.....Wyandotte
Hookey, John A.....Detroit
Hooper, Norman L.....Detroit
Hoops, George B.....Detroit
Hopkins, J. E.....Detroit
Horan, Thomas.....Detroit
Horny, Hugo.....Grosse Pointe
Horton, Reece H.....Detroit
Horvath, Louis O.....Detroit
Horwitz, John B.....Detroit
Hotchkiss, Loris M.....Farmington
Howard, Austin Z.....Detroit
Howard, Phillip J.....Detroit
Howard, W. Leonard.....Northville
Howell, Bert F.....Detroit
Howes, Homer Allen.....Detroit
Howes, Willard Boyden.....Detroit
Howlett, Howard T.....Detroit
Hromadko, Louis.....Detroit
Hubbard, John P.....Detroit
Hubbard, Ralph G.....Detroit
Hudson, J. Stewart.....Grosse Pointe
Hudson, Wm. A.....Detroit
Huegli, Wilfred A.....Detroit
Huff, Reginald G.....Wayne
Hughes, Alberti A.....(L) Detroit
Hull, L. W.....Detroit
Hunt, T. H.....Detroit
Hunt, Verne G.....Detroit
Hunter, Basil H.....Detroit
Hunter, Elmer N.....Detroit
Husband, Charles W.....Detroit
Hussey, Raymond.....Detroit
Hyatt, Jarvis M.....Dearborn
Hyde, Frederick W.....Detroit
Hyde, Frederick W., Jr.....Detroit
Hyman, S. J.....Inkster

Iacobell, Peter H.....Detroit
Igna, Eli J.....Detroit
Ignatius, A. A.....Detroit
Insley, Stanley W.....Detroit
Irvine, Earle Albert.....Detroit
Irwin, W. A.....Detroit
Isaacson, Arthur.....Detroit
Israel, J. G.....Detroit
Iwata, Herbert.....Detroit

Jackson, George F.....Detroit
Jacobson, Samuel D.....Detroit
Jacoby, Myron D.....Detroit
Jaeger, Julius P.....(L) Detroit
Jaekel, C. N.....Detroit
Jaffar, Donald J.....Detroit
Jaffe, J. L.....Detroit
Jaffe, Jacob.....Detroit
Jaffe, Louis.....Detroit
Jahsman, William E.....Detroit
James, Richard G.....Detroit
Jamieson, Thomas J.....Lincoln Park
Janicki, Natalia J.....Eloise
Jarre, Hans A.....Detroit
Jarvis, Harold.....Detroit
Jarzembowski, F. B.....Detroit
Jarsen, Frank J.....Dearborn
Jasion, Lawrence J.....Detroit
Jend, Wm.....(L) Detroit
Jenkins, E. A.....Detroit
Jennings, Charles G.....Detroit
Jentgen, Charles J.....Detroit
Jentgen, L. G.....Detroit
Jeremias, Robert C.....Detroit
Jewell, F. C.....Detroit
Jocz, M. W.....Grosse Pointe Park
Jodar, E. O.....Detroit
John, Hubert R.....Detroit
Johnson, Homer L.....Detroit
Johnson, Ralph A.....Detroit
Johnson, Thomas.....Detroit
Johnson, Vernon P.....Detroit
Johnson, Vincent C.....Detroit
Johnson, W. H. M.....Detroit
Johnston, Charles G.....Detroit
Johnston, Everett V.....Detroit
Johnston, J. A.....Detroit
Johnston, John L.....Detroit
Johnston, Wm. E.....Detroit
Johnstone, Benjamin I.....Detroit
Joinville, E. V.....Detroit
Jones, Adrian R.....Detroit
Jones, Edna M.....Northville
Jones, L. Faunt.....Detroit
Jones, Roy D.....Detroit
Jordan, R. Gerald.....Detroit
Joyce, Stanley J.....Detroit

Juliar, Benjamin.....Detroit
Jurow, Harry N.....Detroit

Kalayjian, Bernard S.....Detroit
Kalder, Ned Block.....Detroit
Kallet, Herbert I.....Detroit
Kallman, David.....Detroit
Kallman, Leo.....Detroit
Kallman, R. Robert.....Detroit
Kamin, Louis E.....Detroit
Kaminski, Zeno L.....Detroit
Kamperman, George A.....Detroit
Kanter, Herman.....Detroit
Kapetansky, A. J.....Detroit
Kapetansky, Nathan J.....Detroit
Kaplita, Walter A.....Detroit
Karr, Herbert S.....Detroit
Kasabach, Harry Y.....Detroit
Kasaback, V. Y.....Detroit
Kasper, Joseph A.....Detroit
Kass, J. B.....Detroit
Katzman, I. S.....Detroit
Kaump, Donald H.....Detroit
Kauppinen, J. A.....Detroit
Kay, Edward W.....Hamtramck
Kazdan, Louis.....Detroit
Kazdan, Morris A.....Allen Park
Keane, Wm. E.....Allen Park
Keating, Thomas F.....Detroit
Kehoe, Henry J.....East Detroit
Keim, H. L.....Detroit
Keith, Kelly.....Detroit
Kelmenson, V. A.....Detroit
Kemler, Walter J.....Ecorse
Kemp, Hardy A.....Detroit
Kennary, James M.....Detroit
Kennedy, Charles S.....Detroit
Kennedy, Donald J.....Detroit
Kennedy, Lester F.....Detroit
Kennedy, Wm. Y.....Detroit
Kennedy, Robert B.....Detroit
Kenning, John C.....(A) Detroit
Kern, W. H.....Garden City
Kernkamp, Ralph.....Detroit
Kernick, M. O.....Detroit
Kersten, Armand G.....Detroit
Kersten, Werner.....Detroit
Kerzman, Joseph H.....Detroit
Keshishian, Sarkis K.....Detroit
Keyes, Eugene Charles.....Dearborn
Keyes, John W.....Detroit
Kibzey, Ambrose T.....Detroit
Kidner, Frederick C.....Detroit
Kimberlin, Kenneth K.....Detroit
King, Edward D.....Detroit
King, Melbourne J.....Detroit
Kingswood, Roy C.....Detroit
Kinsley, George.....Detroit
Kirchner, Augustus.....Detroit
Kirker, J. G.....Detroit
Kirschbaum, Harry M.....Detroit
Klebba, Paul.....Detroit
Klein, William.....Detroit
Kliger, David.....Detroit
Kline, Lewis Le Roy.....Detroit
Kline, Starr L.....Detroit
Klosowski, Joseph.....Detroit
Knaggs, Charles W.....(L) Grosse Pointe
Knaggs, Earl J.....Wyandotte
Knapp, Byron S.....River Rouge
Knapp, Floyd.....Detroit
Knobloch, Edmund J.....Detroit
Knoch, Hubert S.....Detroit
Knox, Ross M.....Ecorse
Koch, John C.....Detroit
Koebel, R. H.....Detroit
Koerber, Edward J.....Detroit
Koessler, George L.....Detroit
Kogut, C. S.....Detroit
Kohn, M. E.....Detroit
Kokowicz, Raymond J.....Detroit
Kopel, Joseph O.....Detroit
Korby, George J.....Detroit
Koren, Louis.....Eloise
Korum, Lyle W.....Detroit
Kossayda, Adam W.....Detroit
Koster, Koert.....Detroit
Kovach, Emery P.....Detroit
Kovan, D. D.....Detroit
Koven, Abraham.....Detroit
Kozlinski, Anthony E.....Detroit
Kozlow, Louise E.....Detroit
Kraft, Raymond B.....Detroit
Kraft, Ruth M.....Detroit
Krass, Edward W.....Detroit
Kraus, John J.....Detroit
Krebs, William T.....Detroit
Kreinbring, George E.....Detroit
Kretzschmar, John C.....Detroit
Krieg, Earl G.....Detroit
Krieger, Harley L.....Detroit
Kritchman, M. J.....Detroit
Kroha, Lawrence.....Detroit
Krohn, Albert H.....Detroit
Krynicki, Francis X.....Detroit
Kubanek, Joseph L.....Eloise
Kucmierz, Francis S.....Detroit
Kuhn, Albert A.....Detroit
Kuhn, Richard F.....Detroit
Kulaski, Chester H.....Detroit
Kullman, Harold J.....Dearborn
Kurcz, J. A.....Detroit
Kurtz, Harry C.....Detroit
Kurtz, I. J.....Detroit
Kwasiborski, S. A.....Wyandotte

LaBerge, James M.....Wyandotte
La Bine, Alfred C.....Detroit
La Core, Ivan.....Detroit
La Ferte, Alfred D.....Detroit
Lakoff, Charles.....Detroit
Lam, Conrad R.....Detroit
Lamberson, Frank A.....Detroit
La Marche, Norman O.....Detroit
Lammy, James V.....Detroit
Lampman, H. H.....Detroit
Landers, M. B., Sr.....Detroit
Landers, M. B., Jr.....Detroit
Lang, Ernst Frederick.....Detroit
Lang, Leonard W.....Detroit
Lange, Anthony H.....Detroit
Lange, Wm. A.....Detroit
Laning, George M.....Detroit
Lansky, Mandell.....Detroit
Lapham, Fred E.....Detroit
Large, A. M.....Detroit
Larsson, Bror H.....Detroit
Lasichak, Andrew G.....Eloise
Lasley, James W.....Detroit
Lathrop, Philip L.....Detroit
Latteier, K. K.....Detroit
Lauppe, Edward H.....Detroit
Lauppe, F. A.....Detroit
Laurisin, Eugene.....Detroit
Lazar, Morton R.....Detroit
Leach, David.....Detroit
Leacock, Robert C.....Detroit
Leader, L. R.....Detroit
Leaver, L. Ross.....Detroit
Leckie, George C.....Detroit
Ledwidge, Patrick L.....Detroit
Lee, Harry E.....Detroit
Le Gallee, George M.....Detroit
Leibinger, Henry R.....Detroit
Leipsitz, Louis S.....Detroit
Leiser, Rudolf.....Eloise
Leithauser, D. J.....Detroit
Leland, Sol.....Detroit
Lemley, Clark.....Detroit
Lemmon, Charles E.....Detroit
Lemmon, Clarence W.....River Rouge
Lentine, James J.....Detroit
Lenz, Willard R.....Grosse Pointe
Lepard, C. W.....Detroit
Lepley, Fred O.....Detroit
Lerman, S. E.....Centerline
Lescohier, Alex W.....Grosse Pointe
L'Esperance, Simon P.....Detroit
Leszynski, J. S.....Detroit
Leucutia, Traian.....Detroit
Levagood, Floyd.....Detroit
Levant, Arthur B.....Detroit
Levin, David M.....Detroit
Levin, Samuel J.....Detroit
Levine, Edward E.....Detroit
Levitt, Edward J.....Detroit
Levitt, Nathan.....Detroit
Levy, Marvin B.....Detroit
Lewis, Charles T.....Detroit
Lewis, J. Hugh.....Wyandotte
Lewis, L. A.....Detroit
Lewis, John R.....Detroit
Lewis, Wilfrid J.....Detroit
Libbrecht, Robert V.....Dearborn
Lichter, Max L.....Detroit
Lichtwardt, Hartman A.....Detroit
Liddicoat, A. G.....Detroit
Lieberman, B. L.....Detroit
Lightbody, James J.....Detroit
Lignell, Rudolph.....Detroit
Lilly, Charles J.....Detroit
Linkner, Leonard.....Detroit
Linton, James R.....Eloise
Lipinski, Stanley L.....Detroit
Lipkin, Ezra.....Detroit
Lippold, Paul H.....Detroit
Lipton, Raymond.....Detroit
Lipschutz, Louis S.....Eloise
Littlejohn, David.....Dearborn
Livingston, George D.....Detroit
Livingston, George M.....(R) Detroit
Lockwood, Bruce C.....Detroit
Lofstrom, James E.....Detroit
Long, Earle C.....Detroit
Long, John J.....Detroit
Longyear, Harold W.....Detroit
Lookanoff, Victor A.....Detroit
Loranger, C. B.....Detroit
Loranger, Guy L.....Dearborn
Lorber, Joseph H.....Detroit
Lorentzen, Edwin H.....Detroit
Lovas, W. S.....Detroit
Love, W. Thomas.....Detroit
Lovell, B. K.....(M) Detroit
Lowe, Adolf.....Detroit
Lowe, Townsend.....Detroit
Lowrie, Wm. L., Jr.....Detroit
Lowry, George L.....Detroit
Luce, Henry A.....Detroit
Lukas, John R.....Detroit
Lutz, Earl F.....Detroit
Lynn, David H.....Detroit
Lynn, Harvey D.....Detroit
Lyons, L. Mason.....Detroit
Lyons, Wm. Harrington.....Detroit
Lytle, Robert P.....Detroit

Maben, Hayward C., Jr.....Detroit
Mabley, J. Donald.....Detroit
MacArthur, Robert A.....Detroit
MacCracken, Frances L.....Detroit
MacDougall, Orrin P.....Detroit
MacFarlane, Howard W.....Detroit
MacGregor, W. W.....Detroit
Mack, Harold C.....Detroit
MacKenzie, Earle D.....Detroit
MacKenzie, Edward P.....Detroit
MacKenzie, Frank M.....Detroit
Mackenzie, John W.....Grosse Pointe
Mackersie, W. G.....Detroit
MacMillan, Francis B.....Detroit
MacMullen, Frank B.....Detroit
MacQueen, Malcolm D.....Detroit
MacPherson, K. C.....Detroit
Maczewski, John E.....Detroit
Madsen, Martha.....Detroit
Magnell, Ralph C.....Detroit
Maguire, Clarence E.....Detroit
Mahoney, Hugh M.....Detroit
Maibauer, F. P.....Wyandotte
Maino, L. J.....Detroit
Maire, E. D.....Detroit
Mair, Harold U.....Detroit
Malachowski, B. T.....Detroit
Malik, Edward A.....Detroit
Malik, Nur M.....Detroit
Malina, Stephen.....Detroit
Maloney, John A.....Detroit
Mancuso, Vincent.....Detroit
Mandiberg, Jack N.....Detroit
Manning, Morey H.....Detroit
Maples, Douglas E.....Detroit
Mapletoft, Kenneth E.....Detroit
Marcotte, Oliver.....Detroit
Marcus, Daniel B.....Detroit
Marinus, Carleton J.....Detroit
Mark, Jerome.....Detroit
Markoe, Rupert C. L.....Detroit
Marks, Ben.....Detroit
Marks, Morris.....Detroit
Marsh, Alton R.....Detroit
Marshall, James R.....Detroit
Marshall, Millard R.....Detroit
Martin, Edward G.....Detroit
Martin, Elbert A.....Detroit
Martin, I. Herbert.....Detroit
Martin, J. B., Jr.....Detroit
Martin, L. R.....Detroit
Martin, Peter A.....Detroit
Martin, R. M.....Detroit
Martin, Richard D.....Detroit
Martin, Wilbur C.....Detroit
Martinez, P. O.....Detroit
Martmer, Edgar.....Detroit
Marwil, T. B.....Detroit
Mason, Percy W.....Detroit
Mateer, John G.....Detroit
Maun, Mark E.....Detroit
May, Earl W.....Alpena
May, Frederick T., Jr.....Detroit
Mayer, E. V.....Detroit
Mayer, Willard D.....Detroit
Maynard, Fred M.....Allen Park
Mayne, Cecil H.....Detroit
McAfee, F. W.....Detroit
McAlpine, Archibald D.....Detroit
McAlpine, Gordon S.....Detroit
McBroom, Russell E.....Detroit
McClelland, Rachel.....Detroit
McClellan, Robert J.....Detroit
McClendon, James J.....Detroit
McClintock, J. J.....Detroit
McClure, Robert W.....Detroit
McClure, Roy D.....Detroit
McClure, Wm. R.....Detroit
McColl, Charles W.....Wyandotte
McColl, Clarke M.....Detroit
McColl, Kenneth M.....Detroit
McCollum, E. B.....Detroit
McCord, Carey P.....Detroit
McCormick, Colin C.....Dearborn
McCormick, C. W.....Detroit
McCullough, Lester E.....Detroit
McDonald, Angus L.....Detroit
McDonald, George O.....Detroit

McDonald, Grant.....Detroit
McEvitt, Wm. G.....Detroit
McFadyen, Hugh A.....Detroit
McGarvah, A. W.....Detroit
McGarvah, Joseph A.....Detroit
McGhee, Richard S.....Detroit
McGillicuddy, Walter E.....Detroit
McGinnis, Daniel H.....Detroit
McGlaughlin, Nicholas D.....Wyandotte
McGough, Joseph M.....Detroit
McGraw, Arthur B.....Grosse Pointe Farms
McGuire, Ivan A.....Detroit
McGuire, M. Ruth.....Detroit
McIntyre, Wm. B.....Detroit
McKean, G. Thomas.....Detroit
McKean, Richard M.....Detroit
McKeever, Robert J.....Detroit
McKenna, Charles J.....Detroit
McKinley, Donald.....Detroit
McKinnon, John D.....Detroit
McLane, Harriett E.....Detroit
McLean, Don W.....Detroit
McLean, Harold G.....Detroit
McPherson, R. J.....Detroit
McQuiggan, Mark R.....Detroit
Mead, John.....Detroit
Meinecke, H. A.....Detroit
Mellen, Hyman S.....Detroit
Menagh, Frank R.....Detroit
Mendelssohn, R. J.....Detroit
Merkel, Charles C.....Grosse Pointe
Merrill, Wm. O.....Detroit
Merritt, Earl G.....Detroit
Metzger, Harry C.....Detroit
Meyer, Ruben.....Detroit
Meyers, M. P.....Detroit
Meyers, P. Marjorie.....Detroit
Meyers, Solomon G.....Detroit
Michels, Julius.....Detroit
Miley, H. H.....Detroit
Millard, Glenn E.....Detroit
Miller, Daniel H.....Detroit
Miller, Elmer B.....Detroit
Miller, Karl.....Detroit
Miller, Kenneth T.....Detroit
Miller, Maurice P.....Trenton
Miller, Myron H.....Detroit
Miller, T. H.....Detroit
Miller, Wm. E.....Detroit
Mills, Clinton C.....Detroit
Mills, Georgia V.....Detroit
Milton, Boynton A.....Inkster
Mintz, Morris J.....Detroit
Mintz, Edward I.....Detroit
Miral, Solomon P.....Detroit
Miro, Morey D.....Detroit
Mishelevich, Sophie.....Detroit
Mitchell, C. Leslie.....Detroit
Mitchell, Gertrude F.....Detroit
Mitchell, Ralston S.....Detroit
Mitchell, W. Bede.....Detroit
Moehlig, Robert C.....Detroit
Mogill, George.....Detroit
Moisides, V. P.....Detroit
Moll, Clarence D.....Detroit
Molner, Joseph G.....Detroit
Moloney, J. Clark.....Birmingham
Mond, Edward.....Detroit
Monfort, Willard.....(L) Highland Park
Montgomery, John C.....Detroit
Monson, Robert C.....Detroit
Montante, Joseph R.....Detroit
Monto, Raymond.....Detroit
Mopper, Coleman.....Detroit
Morand, Louis J.....Detroit
Moriarty, George.....Detroit
Morin, John B.....(L) Detroit
Moritz, H. C.....Detroit
Morley, Harold V.....Detroit
Morley, James A.....Detroit
Moroun, S. J.....Detroit
Morris, Harold L.....Detroit
Morris, Roger S.....Grosse Pointe
Morrison, Marjorie G. E.....Detroit
Morse, Plinn F.....Detroit
Morton, David G.....Detroit
Morton, J. B.....(L) Detroit
Mosee, W. Jones.....Detroit
Mosen, Max M.....Detroit
Moss, E. B.....Detroit
Moss, Selma S.....Detroit
Mossman, John D.....Detroit
Mott, Carlin P.....Detroit
Moulton, Charles.....Detroit
Muellenhagen, Walter J.....Detroit
Munson, F. T.....Detroit
Munson, Henry T.....Detroit
Muntyan, Andrew.....Detroit
Murphy, D. J.....Detroit
Murphy, Eugene.....Detroit
Murphy, John M.....Detroit
Murphy, Scipio G.....Detroit
Murphy, W. M.....Detroit
Murphy, Robert T.....Detroit
Murray, George M.....Detroit
Murray, William A.....Detroit
Muske, Paul H.....Detroit
Myers, Dan W.....Detroit
Myers, Gordon B.....Grosse Pointe

Nagel, Oscar.....Detroit
Nagle, John W.....Wyandotte
Nahigian, Russell.....Dearborn
Naud, Henry J.....Detroit
Naylor, A. E.....Detroit
Naylor, Arthur H.....Detroit
Neeb, Walter G.....Detroit
Neill, Edwin J.....Detroit
Nelson, Harry M.....Detroit
Nelson, Victor E.....Detroit
Neumann, Arthur J.....Detroit
Newbarr, Arthur A.....Detroit
Newman, Max Karl.....Detroit
Nickels, Albert W.....Detroit
Nielsen, Aage E.....Detroit
Nichamin, Samuel J.....Detroit
Nickerson, Dean.....Detroit
Nigro, Norman D.....Detroit
Nill, John B.....Detroit
Nill, Wm. F.....Detroit
Noble, Wm. C.....Ecorse
Nolan, Bernard E.....Detroit
Nolting, Wilfred S.....Detroit
Norconk, A. A.....Detroit
Norris, Edgar H.....Grosse Pointe
Northrop, Arthur K.....(E) Detroit
Norton, A. B.....Detroit
Norton, Charles S.....Detroit
Noth, Paul H.....Grosse Pointe Farms
Novy, R. L.....Detroit
Nowicki, Joseph A.....Detroit
Nunn, James W.....Detroit

O'Brien, E. J.....Detroit
O'Brien, G. M.....Detroit
O'Donnell, Charles.....Dearborn
O'Donnell, David H.....(E) Detroit
O'Donnell, Dayton H., Jr.....Detroit
Ohmart, Galen B.....Detroit
O'Hora, James T.....Detroit
Okun, Milton H.....Detroit
Olechowski, L. W.....(M) Detroit
Olen, Alex.....Detroit
O'Linn, Francis P.....Detroit
Olmsted, George.....Detroit
Olmsted, Wm. R.....Detroit
Olson, James A.....Detroit
Oman, Cyrus F.....Detroit
Oppenheim, J. M.....Detroit
Orecklin, L.....Detroit
Organ, Fred W.....Detroit
Ormond, John K.....Detroit
Ornstein, Charles.....Detroit
O'Rourke, Paul V.....Detroit
O'Rourke, R. M.....Detroit
Osius, Eugene A.....Detroit
Ott, Harold A.....Detroit
Ottaway, John P.....Detroit
Owen, Clarence I.....Detroit
Owen, James A.....Detroit
Owens, Betty B.....Detroit

Palmer, Alice.....Detroit
Palmer, H. Johnston,.....(L) Detroit
Palmer, Milton R.....Detroit
Pangburn, L. E.....Detroit
Panic, Stephen M.....Detroit
Panzner, Edward J.....(E) Detroit
Papp, Sandor D.....Detroit
Parker, Walter R.....(E) Grosse Pointe
Parkinson, Doris.....Detroit
Parr, R. W.....Detroit
Parsons, John P.....Grosse Pointe Park
Pasternacki, Norbert T.....Detroit
Paterson, Walter G.....(L) Detroit
Pawlowski, Jerome.....Detroit
Payne, Eugene.....Detroit
Paysner, Harry A.....Detroit
Peabody, Charles W.....Detroit
Peacock, Lee W.....Highland Park
Pearman, Chas. L. R.....Detroit
Pearse, Harry A.....Detroit
Peck, George A.....Detroit
Peggs, George F.....Detroit
Penberthy, Grover C.....Detroit
Pendy, John M.....Detroit
Pequegnot, Charles F.....(L) Detroit
Perdue, Grace M.....Detroit
Perkin, Frank S.....Detroit
Perkins, Ralph A.....Detroit
Perlis, H. L.....Detroit
Peterman, Earl A.....Detroit
Petix, Samuel C.....Detroit
Pevin, Pauline.....Detroit
Pfeiffer, Rudolph L.....Detroit
Pichette, J. Walton.....Detroit
Pickard, Orlando W.....Detroit
Pierce, Frank L.....Detroit
Pierson, Max J.....Detroit
Pietraszewski, A. W.....Detroit
Pilling, M. A.....Detroit
Pinckard, Karl G.....Dearborn
Pink, Rose M.....Detroit
Pinney, Lyman J.....Detroit
Pino, Ralph H.....Detroit
Piper, Clark C.....Detroit
Piper, Ralph R.....Detroit
Pittman, J. E.....Detroit
Plaggemeyer, H. W.....Detroit
Pliskow, Harold.....Detroit
Podezwa, John W.....Grosse Pointe Woods
Poirier, Ralph A.....Detroit
Pollack, John J.....Detroit
Pool, Walter D.....Detroit
Poos, Edgar.....Detroit
Poretta, Anthony C.....Detroit
Poretta, F. S.....Detroit
Porter, Howard J.....Romulus
Posner, Irving.....Detroit
Pratt, Jean P.....Detroit
Pratt, Lawrence.....Detroit
Prendergast, John J.....Grosse Pointe
Pribor sky, Benjamin H.....Detroit
Price, A. H.....Detroit
Price, Alvin E.....Detroit
Proctor, Bruce.....Detroit
Proud, Robert H.....Flat Rock
Pugliesi, Benedetto.....Detroit
Purcell, Frank H.....Detroit
Purves, William L.....Detroit

Quigley, Eugene.....Dearborn
Quigley, William.....Detroit
Quinn, Edward L.....Detroit

Rabinovitch, Bella.....Detroit
Ragnor, Harold F.....Detroit
Rahm, Lambert P.....Detroit
Raiford, Frank P.....Detroit
Raiford, Frank P., Jr.....Detroit
Rand, Morris.....Los Angeles, Calif.
Raskin, John.....Detroit
Raskin, Morris.....Detroit
Rastello, Peter B.....Detroit
Ratigan, C. S.....Dearborn
Reder, Ben.....Detroit
Redfern, Wm. Earl.....Detroit
Reed, E. Hobart.....(A) Detroit
Reed, H. Walter.....Detroit
Reed, Ivor E.....Detroit
Rees, Howard C.....Detroit
Reichling, Raymond J., Jr.....Detroit
Reid, J. Gilbert.....Detroit
Reid, Wesley G.....Detroit
Reiff, Morris V.....Detroit
Reinbolt, Charles A.....(L) Detroit
Reinsh, Ernest R.....Detroit
Reisman, Nathan J.....Detroit
Renaud, G. L.....(E) Detroit
Rennell, Leo P.....Detroit
Reveno, Wm. S.....Detroit
Rexford, W. K.....Detroit
Reye, H. A.....Detroit
Reyner, C. E.....Detroit
Reynolds, Lawrence.....Detroit
Reynolds, R. P.....Detroit
Rezanka, Harold J.....Detroit
Rhoades, F. P.....Detroit
Rice, Harold B.....Detroit
Rice, Meshel.....Detroit
Richardson, Allan L.....Detroit
Richardson, Robert P.....Wayne
Rick, Paul J.....Detroit
Ridge, Ralph W.....Wyandotte
Rieden, James A.....Detroit
Rieckhoff, George G.....Detroit
Rieg, John F.....Detroit
Rieger, John B.....Detroit
Rieger, Mary H.....Detroit
Riseborough, E. C.....Detroit
Rizzo, Frank.....Grosse Pointe Park
Rizzo, Paul.....Detroit
Robb, Ed. L.....Detroit
Robb, Herbert F.....Belleville
Robb, J. Milton.....Grosse Pointe Village
Roberts, Arthur J.....Lincoln Park
Robertson, Stanley B.....Detroit
Robertson, Tom H.....Detroit
Robins, Samuel C.....Detroit
Robinson, Edwin L.....Detroit
Robinson, Fred L.....Dearborn
Robinson, George W.....Detroit
Robinson, Harold A.....Detroit
Robinson, Howard.....Detroit
Robinson, R. J.....Detroit
Rogers, Aaron Z.....Grosse Pointe Woods
Rogers, George E. B.....Detroit
Rogers, James D.....Wyandotte
Rogin, James R.....Detroit
Rogoff, A. S.....Detroit
Rohde, Paul C.....Detroit
Roland, Charles F.....Detroit
Rom, Jack.....Detroit
Roman, Stanley J.....Detroit
Roney, Eugene H.....Detroit
Rosbolt, Oscar P.....Detroit

Rose, Bernard.....Detroit
Rosefield, John L.....Detroit
Rosen, Harold M.....Detroit
Rosen, Robert.....Detroit
Rosenwach, Felix F.....Detroit
Rosenthal, Louis H.....Detroit
Rosenthal, Samuel.....Detroit
Ross, Ben C.....Detroit
Ross, Donald G.....Detroit
Ross, Hyman.....Detroit
Rotarius, E. M.....Detroit
Roth, Edward T.....Detroit
Roth, Theodore I.....Detroit
Rothbart, H. B.....Detroit
Rothman, Emil D.....Detroit
Rothman, H. R.....Detroit
Rottenberg, Leon.....Detroit
Rowda, Michael S.....Detroit
Rowe, Robert.....Detroit
Rowell, Robert C.....Eloise
Rowell, Wilfred J.....Detroit
Rucker, Julian J.....Detroit
Ruedemann, A. D.....Detroit
Rueger, Milton J.....Detroit
Rueger, Ralph C.....Detroit
Runge, Edward F.....Dearborn
Rupprecht, Emil F.....Detroit
Ruskin, I. W.....Detroit
Ruskin, Samuel H.....Detroit
Russell, John C.....Detroit
Rutzen, Arthur C.....Detroit
Rydzewski, Joseph B.....Detroit
Ryerson, Frank L.....Detroit

Sack, A. G.....Detroit
Sa'di Lutfi.....Detroit
Sadowski, Roman.....Detroit
Sage, Bernard A.....Dearborn
Sage, Edward O.....(L) Detroit
Sage, Thomas.....Detroit
Sager, E. L.....Detroit
St. Amour, Hector J.....Detroit
St. Louis, R. J.....River Rouge
Sakorraphos, Stelios N.....Detroit
Salchow, Paul T.....Detroit
Salowich, John N.....Allen Park
Saltzstein, Harry C.....Detroit
Sand, Harry H.....Detroit
Sander, I. W.....Detroit
Sanders, Alex W.....Detroit
Sanderson, Alvord R.....Grosse Pointe Park
Sanderson, Suzanne.....Detroit
Sandler, Nathaniel.....Detroit
Sands, G. E.....Detroit
Sandweiss, David J.....Detroit
Sapala, M. Andrew.....Detroit
Sargent, William R.....Detroit
Sarracino, John R.....Detroit
Sauk, John J.....Detroit
Sauter, Simon H.....Detroit
Savignac, Eugene M.....Detroit
Scarney, Herman D.....Detroit
Schaefer, Robert L.....Detroit
Schaeffer, Martin.....Detroit
Schembeck, I. S.....Detroit
Schenden, A. J.....Melvindale
Schiller, A. E.....Detroit
Schinagel, Geza.....Detroit
Schirack, Ray.....Detroit
Schkloven, Norman.....Detroit
Schlacht, George F.....Romulus
Schlafer, Nathan H.....Detroit
Schlemer, John H.....Detroit
Schlesinger, Henry.....Detroit
Schmaltz, John D.....Detroit
Schmidt, Harry E.....Detroit
Schmidt, Milton R.....Trenton
Schmier, Burton L.....Detroit
Schmitt, Norman L.....Detroit
Schneck, Robert J.....Detroit
Schneider, Curt P.....Detroit
Schoenfield, Gilbert D.....Detroit
Scholes, Daniel R.....Detroit
Schooten, Sarah S.....Detroit
Schorr, Robert L.....(E) Detroit
Schreiber, Frederic.....Detroit
Schroeder, Carlisle F.....Detroit
Schulte, Carl H.....Detroit
Schultz, Ernest C.....Detroit
Schultz, Robert F.....Detroit
Schwartz, Ben.....Detroit
Schwartz, Louis A.....Detroit
Schwartz, Oscar D.....Detroit
Schwartzberg, Joseph A.....Detroit
Schweigert, C. F.....Detroit
Sciarrino, Stanley V.....Detroit
Scott, R. J.....Detroit
Scott, William J.....Grosse Pointe Farms
Screen, Raymond J.....Trenton
Scruton, Foster D.....Detroit
Seabury, Frank P.....Eureka Springs, Ark.
Secord, Eugene W.....Detroit
Seeley, James B.....Dearborn
Seeley, Ward F.....Detroit
Segar, Lawrence F.....Detroit
Seibert, Alvin H.....Grosse Pointe Park
Seiferlein, Archie L.....Detroit
Selby, C. D.....Detroit
Sellers, Charles W.....Detroit
Sellers, Graham.....Detroit
Sengpiel, Gene.....Detroit
Serrester, Bernard F.....Detroit
Sewell, George S.....Detroit
Shafarman, Eugene.....Detroit
Shaffer, Joseph H.....Detroit
Shaffer, Loren W.....Detroit
Shafter, Royce R.....Detroit
Shannon, Wm. F.....Detroit
Shapiro, I. Allen.....Detroit
Shapiro, Jacob.....Detroit
Shapiro, Oscar U.....Detroit
Shapiro, Reuben I.....Detroit
Sharrer, Charles H.....Detroit
Shaw, Norman D.....Dearborn
Shaw, Robert G.....(L) Detroit
Shawan, H. K.....Detroit
Sheldon, John A.....Detroit
Shellhamer, Claire S.....Detroit
Shelton, C. F.....Detroit
Sheppard, Emma L. W.....Center Line
Sherman, Louis L.....Pecayune, Miss.
Sherman, Wm. L.....Detroit
Sherrin, Edgar R.....Detroit
Sherwood, De Witt L.....Detroit
Shewchuk, Alexander P.....Detroit
Shields, W. L.....Detroit
Shifrin, Peter G.....Detroit
Shiovitz, Louis.....Detroit
Shippey, M. R.....Eloise
Shipton, W. Harvey.....Detroit
Shlain, Benjamin.....Detroit
Shore, O. J.....Detroit
Shotwell, Carlos W.....Detroit
Shulak, Irving B.....Detroit
Shumaker, Edw. J.....Detroit
Shurly, Burt R.....(E) Detroit
Siddall, Roger S.....Detroit
Sieber, Edward H.....Dearborn
Siefert, John L.....Detroit
Siefert, Wm. A.....Detroit
Siegel, Henry.....Detroit
Sill, Jack A.....Detroit
Silvarman, I. Z.....Detroit
Silver, Israel W.....Detroit
Silverman, Max.....Detroit
Silverman, M. M.....Detroit
Simmons, Donald R.....Detroit
Simon, Emil R.....Detroit
Simon, Heinz G.....Wyandotte
Simpson, C. E.....Detroit
Sinclair, James W.....Detroit
Singer, Floyd W.....Dearborn
Sippola, George W.....Detroit
Sisson, John M.....Detroit
Skinner, W. Clare.....Detroit
Sklover, I. J.....Detroit
Skrzycki, Stephen S.....Detroit
Skully, E. J.....Detroit
Sladen, Frank J.....Grosse Pointe
Slabetke, Vincent E.....Detroit
Slate, Raymond N.....Detroit
Slaughter, Fred M.....Detroit
Slaugenhaupt, J. G.....Detroit
Slazinski, Leo W.....Detroit
Slipson, Edith.....Detroit
Slevin, John G.....Detroit
Sliwin, Edward P.....Detroit
Sluzky, Joseph.....Detroit
Small, Henry.....Detroit
Smathers, Homer M.....Detroit
Smeck, Arthur R.....Detroit
Smith, Charles E.....Detroit
Smith, Clarence V.....Detroit
Smith, Claude A.....River Rouge
Smith, F. Janney.....Detroit
Smith, Gerrit C.....Detroit
Smith, Henry L.....Detroit
Smith, J. Allen.....Detroit
Smith, James A.....Detroit
Smyka, Edward J.....Detroit
Smyth, Charley J.....Eloise
Snedeker, Bernard C.....Detroit
Snow, L. W.....Northville
Snyder, Arthur M.....Detroit
Sobel, Robert A.....Detroit
Sokolov, Raymond A.....Detroit
Somers, Donald C.....Detroit
Sonda, Lewis P.....Detroit
Sorock, Milton L.....Detroit
Spademan, Loren C.....Detroit
Spalding, Edward D.....Detroit
Sparling, Harold I.....Northville
Sparling, Irene M.....Northville
Speck, Carlos C.....Detroit
Spector, Maurice J.....Detroit
Spero, Gerald D.....Detroit
Sperry, Frederick L.....Detroit
Spiro, Adolph.....Detroit
Springborn, B. R.....Detroit
Sprunk, Carl.....Detroit
Sprunk, John P.....Detroit
Spurrier, Ethelbert.....Detroit
Squires, W. H.....Detroit
Stafford, Frank W. J.....Detroit
Stalker, Hugh.....Grosse Pointe
Stamell, Meyer.....Detroit
Staniszewski, Casimir.....Detroit
Stanton, James M.....Detroit
Stanton, Myron.....Detroit
Stapleton, Wm. J., Jr.....(L) Detroit
Starrs, Thomas C.....Detroit
Staub, Howard P.....Detroit
Stearns, Alex B.....Grosse Pointe Woods
Steele, Hugh.....Detroit
Stefani, E. L.....Detroit
Stefani, Raymond T.....Detroit
Stein, Albert H.....Detroit
Stein, Emory.....Detroit
Stein, James R.....Ferndale
Stein, Saul C.....Van Dyke
Steinbach, Henry B.....Detroit
Steinberger, Eugene.....Detroit
Steiner, Frederick.....Garden City
Steiner, Gabriel.....Detroit
Steiner, Louis J.....Detroit
Steinhardt, Milton J.....Detroit
Stellhorn, Chester E.....Detroit
Stellhorn, Mary Christine.....Detroit
Sterba, Richard.....Detroit
Sterling, Lawrence S.....Detroit
Sterling, Robert R.....Detroit
Stern, Charles A.....Detroit
Stern, Harry L.....Detroit
Stern, Leonard H.....Detroit
Stern, Louis D.....Detroit
Stevenson, Edward L.....Detroit
Stewart, Harry L.....Detroit
Stewart, Thomas O.....Detroit
Stirling, Alex M.....Detroit
Stith, Dwight E.....Detroit
Stockwell, B. W.....Detroit
Stofer, Bert E.....Detroit
Stokfisz, T.....Detroit
Stout, Lindley H.....Detroit
Straith, Claire L.....Detroit
Strand, Martin E.....Detroit
Stricker, Henry D.....Detroit
Strickroot, Fred L.....Detroit
Strohschein, Don F.....Detroit
Stryker, Joan C.....Grosse Isle
Stryker, Walter A.....Wyandotte
Stubbs, C. T.....Detroit
Stubbs, Harold W.....Detroit
Stuecheli, Milton B.....Grosse Pointe
Sugar, David I.....Detroit
Sugar, H. Saul.....Detroit
Sullivan, Hugh A.....Detroit
Summers, Wm. A.....Detroit
Summers, Wm. S.....Detroit
Surbis, John P.....Detroit
Sutherland, J. M.....Detroit
Swanson, Carl W.....Detroit
Swanson, Cleary N.....Detroit
Swanson, Robert G.....Detroit
Sweeny, Donald, Jr.....Detroit
Swift, Karl L.....Detroit
Switzer, Bertrand C.....Detroit
Sylvan, Melvin M.....Van Dyke
Szappanyos, Bela T.....Detroit
Szedja, J. C.....Detroit
Szladek, Frank J.....Wyandotte
Szmigiel, A. J.....Detroit
Talbot, Frank G.....Detroit

Tamblyn, E. J.....Detroit
Tapert, Julius C.....Detroit
Tasker, Helen.....Detroit
Tassie, Ralph N.....Detroit
Tatelis, Gabriel.....Detroit
Taylor, Ivan B.....Detroit
Taylor, Nelson M.....Grosse Pointe
Taylor, Reu Spencer.....(L) Detroit
Tazzioli, Henry A.....Detroit
Tear, Malcolm J.....Detroit
Teitelbaum, Myer.....Detroit
Tenaglia, Thomas A.....Ecorse
Tenerowicz, Rudolph G.....Detroit
Test, Frederick C., II.....Mt. Clemens
Texter, Elmer C.....Detroit
Thaler, Wm. J.....Detroit
Thompson, Alderman.....Detroit
Thompson, Arthur Lee.....Detroit
Thompson, H. E.....Detroit
Thompson, H. O.....Detroit
Thompson, W. A.....Detroit
Thomson, Alexander.....(E) Detroit
Thornell, Harold E.....Detroit
Thorstad, Merrill J.....Detroit
Thosteson, George C.....Detroit
Tichenor, E. D.....Detroit
Toepel, Otto T.....(E) Detroit
Tomsu, Charles L.....Detroit
Top, Franklin H.....Detroit
Townsend, Frank M.....Detroit

Tregenza, W. Kenneth....Detroit
Troester, George A....Detroit
Trombino, James F....Detroit
Trombley, Bryan....Detroit
Trombley, Joseph J., Jr....Detroit
Truszkowski, Edward G....Detroit
Trythall, S. W....Detroit
Tulloch, John....Detroit
Tupper, Roy D....Detroit
Turbett, Claude W....Detroit
Turcotte, Vincent J....Detroit
Turkel, Henry....Detroit
Turnbull, Jack V....Detroit
Tyson, Wm. E. E....(L) Detroit

Ujda, Chester J....Detroit
Ulbrich, Henry L....Detroit
Ulrich, Willis H....Detroit
Umphrey, Clarence E....Detroit
Usher, Wm. Kay....Detroit

Vale, C. Fremont....Detroit
Van Baalen, M. R....Detroit
Van Becelaere, Lawrence H....Ecorse
Van Eck, James E....Detroit
Van Gundy, Clyde R....Detroit
Van Nest, A. E....Detroit
Van Rhee, George....Detroit
Van Riper, Steven L....Detroit
Vardon, Colin C....Detroit
Vardon, Edward M....Detroit
Vasu, V. O....Detroit
Vincent, James Le Roi....Detroit
Voegelin, Adolph E....Detroit
Vogel, Hymen A....Detroit
Vokes, Milton D....Detroit
Vollmar, G. Kenneth....Detroit
Von Der Heide, E. C....Detroit
Vossler, A. E....Detroit
Vreeland, C. Emerson....Detroit

Waddington, Joseph E. G....(E) Detroit
Waggoner, C. Stanley....Detroit
Waggoner, Lyle G....Detroit
Wainger, M. J....Detroit
Wainstock, Michael....Detroit
Wakeman, E. M....Dearborn
Waldbott, George L....Detroit
Walker, Enos G....Detroit
Walker, J. Paul....Detroit
Walker, Leo Whitney....Detroit
Walker, Roger V....Detroit
Wallace, S. Willard....Detroit
Walls, Arch....Detroit
Walser, Howard C....Detroit
Walsh, Charles R....Detroit
Walsh, Francis P....Detroit
Walters, Albert G....Detroit
Waltz, Frank D. B....Detroit
Waltz, Paul J....Detroit
Ward, George F....Detroit
Warden, Horace F. W....Detroit
Warner, P. L....Detroit
Warren, Irving A....Detroit
Warren, Wadsworth....Detroit
Wasserman, Lewis C....Detroit
Waszak, Charles J....Detroit
Watson, Douglas J....Detroit
Watson, Harwood G....Detroit
Watson, J. Edwin....Detroit
Watson, Robert W....Detroit
Watts, Frederick B....Detroit
Watts, John C....Detroit
Watts, John J....Detroit
Wayne, M. A....Detroit
Weaver, Clarence E....Detroit
Weaver, Delmar F....Grosse Pointe
Weber, Karl W....Detroit
Webster, John E....Detroit
Weed, Milton R....Detroit
Wehenkel, Albert M....Detroit
Weiner, M. B....Detroit
Weingarden, David H....Detroit
Weinstein, Jacob....Detroit
Weisberg, A. Allen....Detroit
Weisberg, Harry....Detroit
Weisberg, Jacob....Detroit
Weisenthal, Irvin....Detroit
Weiser, Frank A....Detroit
Weiss, C. P....Detroit
Weiss, Jack I....Detroit
Weiss, J. G....Detroit
Welch, John H....Columbus, Ohio
Weller, Charles N....Detroit
Wells, Martha....Detroit
Weltman, Carl G....Detroit
Wendel, Jacob S....Detroit
Wenzel, Jacob F....Detroit
Weston, Bernard....Detroit
Weston, Earl E....Detroit
Weston, Horace L....Detroit
Weyher, Russell F....Detroit
Whalen, Neil J....Detroit
Wharton, Thomas V....Wyandotte
Wheeler, Stewart C....Detroit
Whinnery, Randall A....Detroit
White, Milo R....Detroit
White, Milton W....Detroit
White, Prosper D., Jr....Detroit
White, Theodore M....Detroit
Whitehead, L. S....Detroit
Whitehead, Walter K....Detroit
Whiteley, Robert K....Detroit
Whitney, Elmer L....Detroit
Whitney, Rex E....Detroit
Whittaker, Alfred H....Detroit
Wiant, John L....Detroit
Wickham, A. B....(L) Detroit
Wiechowski, Henry E....Detroit
Wiener, I....Detroit
Wiener, Morton....Detroit
Wietersen, Fred K....Detroit
Wight, Fred B....Detroit
Wilcox, Leslie F....Detroit
Wilhelm, Seymour....Detroit
Wilkinson, Arthur P....Detroit
Williams, C. J....Detroit
Williamson, John C....Detroit
Wills, J. N....Detroit
Wilner, Irvin....Detroit
Wilson, Andrew....Detroit
Wilson, Gerald A....Detroit
Wilson, M. C....Detroit
Wilson, Stuart C....Detroit
Wilson, Walter J....(E) Detroit
Wilson, W. J., Jr....Detroit
Wiren, Lennart W., Jr....Detroit
Wishropp, E. A....Detroit
Wisner, Harold E....Detroit
Wissman, H. C....Dearborn
Wittenberg, Arthur A....Detroit
Wittenburg, Sydney S....Detroit
Witter, Frank C....Detroit
Witter, Joseph A....Detroit
Witus, Carl....Detroit
Witus, Morris....Detroit
Witwer, Eldwin R....Detroit
Wolfe, Max O....Detroit
Wollank, Helen Wilson....Detroit
Wollenberg, Robert A. C....Detroit
Wood, Kenneth A....Detroit
Woodburne, H. L....Detroit
Woodry, Norman L....Detroit
Woods, H. B....Brown City
Woods, W. Edward....Detroit
Woodworth, Wm. P....Detroit
Worzniak, Joseph J....Wyandotte
Wreggit, W. R....Detroit
Wright, Charles....Detroit
Wright, Lance S....Detroit
Wruble, Joseph....Detroit
Wunsch, Richard E....Detroit
Wygant, Thelma....Dearborn

Yesayian, H. G....Detroit
Yott, William J....Detroit
Young, Donald A....Detroit
Young, Donald C....Detroit
Young, Lloyd B....Detroit
Young, Viola M....Detroit

Zemens, Joseph L....Detroit
Zbudowski, A. S....Hamtramck
Zbudowski, Myron B....Detroit
Zemens, Joseph L....Detroit
Zielinski, Charles J....Detroit
Zinn, George H....Detroit
Zinterhofer, John, Jr....Detroit
Zinterhofer, Louis....Detroit
Zlatkin, Louis....Detroit
Zonnis, Marian....Detroit
Zukowski, Sigmund A....Detroit

Wexford County

Daugherty, R....Cadillac
Davidson, John G....Cadillac
Holm, Augustus....Leroy
Holm, Benton....Burlington, Vt.
Inman, J. C....Lake City
Landy, George R....Cadillac
Lomman, Ralph....Manton
McCall, James H....Lake City
McManus, Edwin....Mesick
Masselink, H. J....McBain
Merritt, C. E....Manton
Moore, G. P....Cadillac
Moore, Sair C....Cadillac
Murphy, Michael R....Cadillac
Purdy, Calvin E....Buckley
Seltzer, Sol Norris....Redlands, Calif.
Showalter, Lawrence E....Cadillac
Smith, Fred R....Lake City
Smith, Wallace J....Cadillac
Tornberg, Gordon C....Cadillac



amebiasis

...now endemic in the U. S.?



Formerly considered a tropical disease, amebiasis is more recently reported[1, 2] as "extremely common" and even "endemic" in this country.

Because early treatment has such an important bearing on prognosis, investigators stress the importance of prompt recognition through careful stool examination.

Destructive to the cysts of Endamoeba histolytica and especially valuable in sterilizing "cyst-carriers" is the high-iodine-containing amebacide, DIODOQUIN.

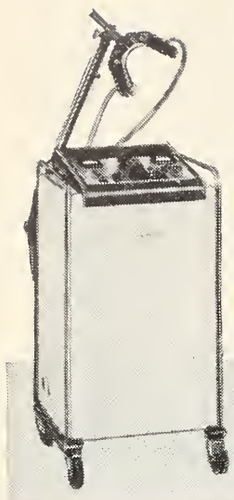
Diodoquin[3] "is well tolerated....It can readily be taken by ambulant patients and, therefore, eliminates the necessity of hospitalization."

SEARLE ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION **DIODOQUIN.®**

(5, 7-diiodo-8-hydroxyquinoline)

RESEARCH
IN THE SERVICE
OF MEDICINE

1. Cholgren, W. S., and Boker, A. B.: Tropical Diseases: Involvement of Nervous System, Arch. Poth. 41:66 (Jon.) 1946.
2. Browne, D. C.; McHordy, G., and Spellberg, M. A.: Stotisticol Evoluotion of Amebiosis, Gostroenterology 4:154 (Feb.) 1945.
3. Manson-Bohr, P.: Some Tropical Diseases in Generol Practice: "A Post-War Legacy." Glasgow M. J. 27:123 (May) 1946.



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Use This Diathermy Check List . . .

( ) **DOES IT HAVE THIS SEAL?**
Council-Acceptance means that it has met rigid requirements for clinical efficiency.

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(In Canada: Is it CDT-Approved?)
A Type-Approval certificate number is issued on all FCC-Approved apparatus.

( ) **IS IT APPROVED BY UNDERWRITERS' LABORATORIES?**
The "UL" seal indicates safe construction, meets insurance requirements.

( ) **IS IT CRYSTAL CONTROLLED?**
Crystal control means precision frequency control and stability of operation.

( ) **IS MANUFACTURER EXPERIENCED?**
Responsibility does not end with the sale. Your diathermy should be purchased for the future from an experienced maker.

The Answer is "YES" to all Questions about the BURDICK X 85 SHORT WAVE DIATHERMY

FOR EFFICIENT SHORT WAVE APPLICATION . . .

The Burdick Contour Applicator. Smooth, unbroken treatment surface which curves to fit body surfaces. One continuous coil provides more even distribution of heat.

See the Burdick X 85 Short Wave Diathermy in the showrooms of your local Burdick dealer, or write us direct, The Burdick Corporation, Milton, Wisconsin, for descriptive literature.

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Woman's Auxiliary

TWENTY-SECOND ANNUAL CONVENTION

The twenty-second annual convention of the Woman's Auxiliary to the Michigan State Medical Society will be held in the Fort Shelby Hotel, Detroit, September 21, 22 and 23, 1948.

A most cordial invitation is extended to the wives of all doctors attending the session of the Michigan State Medical Society to participate in all convention events. Whether Auxiliary members or not, the wives of physicians will be most welcome.

Auxiliary headquarters will be in the main lobby of the Fort Shelby Hotel, and the Wayne County Auxiliary is providing a Hospitality Room, the facilities of which are to be at the disposal of guests at all times.

Please register early and purchase your tickets for all social functions. These will be sold only at Auxiliary headquarters.

Registration Hours

Tuesday, September 21.....9 a.m.- 4 p.m.
Wednesday, September 22.....9 a.m.- 4 p.m.
Thursday, September 23.....9 a.m.-12 m.

Program

Tuesday, September 21

6:00 p.m. Subscription dinner—Sky Room
8:00 p.m. Bridge

Wednesday, September 22

11:00 a.m. Pre-Convention Board Meeting—River Room
12:30 p.m. Luncheon—Sky Room
5:00 p.m. Get-Acquainted Hour honoring the National President, Mrs. Luther K. Kice—State Presidents—Music by "The Dukes"
6:00 p.m. Banquet—Spanish Room
Speakers—Haven Emerson, M.D., New York; Warren W. Furey, M.D., Chicago

Thursday, September 23

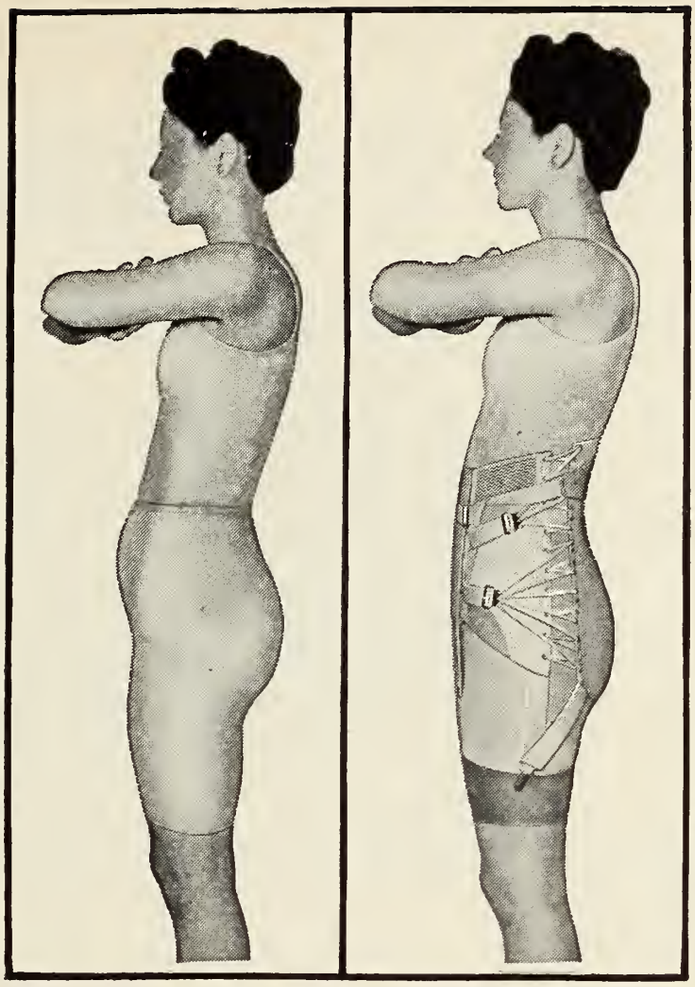
10:00 a.m. Annual Meeting—Spanish Room
12:30 a.m. Annual Luncheon—Crystal Room
Speaker: E. F. Sladek, M.D., Traverse City, President-Elect, MSMS. Subject: "Working Together."
"Ye Aulde Album Style Show" by members of Wayne County Auxiliary

Local Committee on Convention Arrangements

Mrs. L. Paul Sonda is chairman of the Committee on Convention Arrangements, with Mrs. Frederick G. Buesser and Mrs. William L. Foster acting as co-chairmen.

Those in charge of special activities are: *Credentials and Registration*—Mrs. William L. Foster; *Social*—Mrs. Norman O. LaMarche; *Hospitality*—Mrs. Frederick G. Buesser; *Publicity*—Mrs. Clarence L. Candler; *Finance*—Mrs. Robert L. Novy; *Program*—Mrs. William L. Sherman; *Flowers*—Mrs. Audrey O. Brown; *Pages*—Mrs. Milton A. Darling; *Courtesy*—Mrs. Howard P. Doub; *Printing*—Mrs. Herman D. Scarney.

Say you saw it in the Journal of the Michigan State Medical Society



Patient of intermediate type of build; roentgenograms showed spondylolisthesis, grade 1, with congenital defects. Symptoms developed after a fall on the ice during pregnancy.

Same patient after application of support. Patient reported relief from pain which was confined to the back and called attention to the ease and comfort in the wearing of the support.

Aid in conservative treatment when the fifth lumbar vertebra slips on the sacrum

...advantages of the CAMP lumbosacral supports

...***THE WELL BONED BACK***—Curves in and under the gluteal muscles, relieving the tension of these muscles on their attachments.

Wide shaped piece of material at top (fastening in front) holds the support still more closely about the lumbar spine.

...***THE SIDE LACING ADJUSTMENT*** — Assists in steadying the pelvic girdle.

It also allows for reinforcing with aluminum steels or Camp Spinal Brace.

The elastic releases make for comfort.

S. H. CAMP AND COMPANY • JACKSON, MICHIGAN

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. . . . . NEWS MEDICAL

"A good thing to remember, and a better thing to do, is to work with the construction gang and not with the wrecking crew."

* * *

The Michigan Allergy Society at a meeting held May 20, 1948, elected the following officers: Samuel J. Levin, M.D., president; Meryl M. Fenton, M.D., vice president; and Homer A. Howes, M.D., secretary-treasurer.

* * *

Harry C. Saltzstein, M.D., and *Walter S. Johnson, M.D.,* of Detroit, have a paper published in the March, 1948, issue of Gastroenterology, "Carcinoma of the Pancreas: Operative Problems."

* * *

Periodic Health Examination.—The modern physician's function is not only to treat disease, but to prevent disease and to offer sound helpful advice that can make life more pleasant and comfortable.

* * *

The Michigan Society of Anesthesiologists will hold its annual meeting and election of officers in Detroit on September 22, 1948. This will be a dinner meeting. The place of meeting will be announced later.

* * *

V.A. announces that contracts totalling $4,517,767 for the construction of a veterans hospital at Saginaw, Michigan, have been awarded. The hospital will have 200 general medical and surgical beds.

* * *

The Kent County Medical Society's Bulletin of April contained a very interesting "history of compulsory health insurance in Great Britain, France, and Germany." The expansion of compulsory health insurance in these three foreign countries was graphically portrayed in the charts.

* * *

Only 33 per cent of hospitals this year have their full quota of interns, while 25 per cent have less than half, and 12.5 per cent of all approved hospital have not been able to obtain any, according to the *Bulletin* of the Kalamazoo Academy of Medicine, May, 1948, number.

* * *

The New York State Society of Anesthesiologists announces its third postgraduate assembly, December 9-10,

(Continued on Page 796)



• Licensed by State of Michigan, Dept. of Mental Health • Registered by American Medical Association

ST. JOSEPH'S RETREAT



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Under direction of
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Newly reorganized and modernized for individualized care and treatment of the nervous and mentally ill and alcoholics.

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Leading Teachers From All Over the U. S.

HEMATOLOGY AND NEUROLOGY
September 13-18, 1948

CARDIOVASCULAR AND RESPIRATORY DISEASES
September 20-25, 1948

Both Courses Limited To 100 And Open To Physicians In Good Standing In Their Local Medical Societies. Fee $50.00 Each Course.

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CHICAGO MEDICAL SOCIETY, 30 NO. MICHIGAN, CHICAGO 2. ILLINOIS



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MEN'S WEAR • 617 WOODWARD

DETROIT 26 • MICHIGAN

(Continued from Page 794)

1948, at Hotel New Yorker, New York City. For complete program write Lewis H. Wright, M.D., general chairman, Suite 1503, 745 Fifth Ave., New York 22.

* * *

The American Congress of Physical Medicine will hold its twenty-sixth annual session at the Statler Hotel, Washington, D. C., September 7, 8, 9, 10, 11. For full information write A.C.P.M., 30 North Michigan Ave., Chicago 2, Illinois.

* * *

The thirty-fourth Clinical Congress of the American College of Surgeons will be held in Los Angeles, at the Biltmore Hotel, October 18 to 22, 1948. For program and further information write A. C. of S., 40 E. Erie St., Chicago 11, Illinois.

* * *

At the St. Clair County Medical Society Annual All-Day Clinic, held at St. Clair Inn, on June 18, W. D. Gatch, M.D., and associates of Indianapolis, Indiana, presented the program. One hundred and thirty-seven attended a very interesting meeting.

* * *

J. Earl McIntyre, M.D., secretary of the Michigan State Board of Registration in Medicine, who is also a member of the National Board of Medical Examiners of the United States, was re-elected to a six-year term on the National Board at its annual meeting on May 22, 1948, in Philadelphia.

* * *

The First World Health Assembly began in Geneva, Switzerland, June 24, when the World Health Organization became a permanent agency of the United Nations. U. S. headquarters for WHO are at 350 Fifth Avenue, New York 1. This organization has been approved by the American Medical Association.

* * *

Good Health is
Good business for agriculture;
Good business for labor;
Good business for business;
Good business for everybody.
—National Planning Association, Pamphlet No. 62, 800 21st N.W., Washington 6, D. C.

* * *

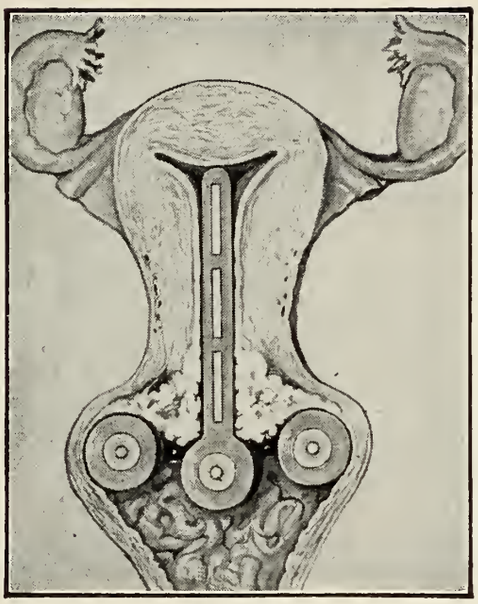
The 1948 Assembly and Convocation of the United States Chapter, International College of Surgeons, will be held at Kiel Auditorium, St. Louis, November 16-19, 1948. For copy of program write R. M. Klemme, M.D., Professor of Surgery, St. Louis University, 4952 Maryland Ave., St. Louis, Missouri, general chairman of arrangements.

* * *

Theodore G. Klumpp, M.D., president of Winthrop-Stearns Inc., was recently elected president of the American Pharmaceutical Manufacturers Association at its annual convention in Havana, Cuba. Dr. Klumpp, who is a graduate of Princeton University and of Harvard Medical School, is chairman of the Board of Governors

(Continued on Page 798)

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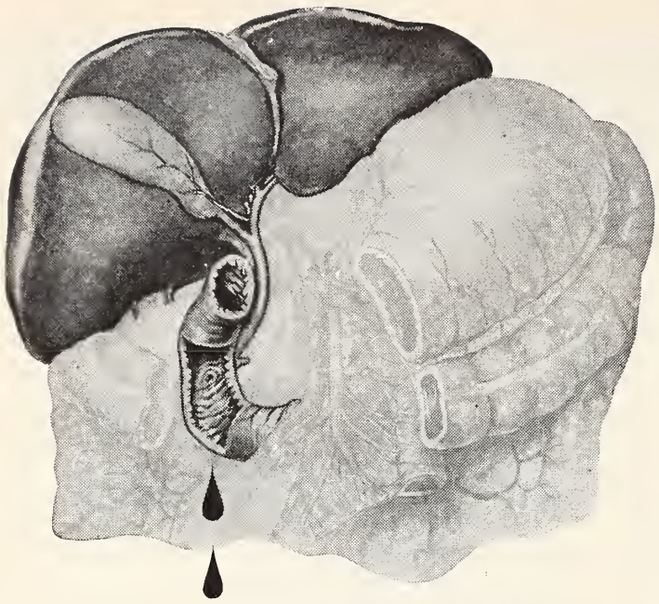
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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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(Continued from Page 796)

of the National Vitamin Foundation. Before becoming associated with Winthrop, Dr. Klumpp taught internal medicine at Yale Medical School and served as secretary of the Council on Pharmacy and Chemistry of the AMA.

* * *

Child Death Rate Falls 60 Per Cent.—The death rate of children one to four years old has dropped 60 per cent since 1930, according to Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Co.

He noted drastic reductions in deaths resulting from diarrhea, enteritis, childhood diseases and pneumonia. —*Detroit Free Press, June 1, 1948.*

* * *

Harry L. Stern, M.D., assumed the office of president of the West Side Medical Society for the year 1948-49; R. F. Fenton, M.D., was chosen as president-elect; O. A. Capano, M.D., secretary, and S. O. Cotton, M.D., treasurer, at the WSMS annual meeting held April 14, 1948. L. J. Gariepy, M.D., retiring president, presented the exaugural address.

* * *

Chicago Medical Society offers two postgraduate courses: one in hematology and neurology, September 13-18; and another in cardiovascular and respiratory diseases, September 20-25. Both sessions will be held in Thorne Hall, Northwestern University Medical School. For full information write Postgraduate Medical Education Committee Chairman, Chicago Medical Society, 30 N. Michigan Ave., Chicago 2, Illinois.

* * *

Senate Resolution 249, introduced into the Senate Health Committee on June 4, calls for a cessation of activity on all health bills until March 15, 1949—with the interval being used for study of health legislation by the Senate Labor Committee.

This resolution was adopted by the Senate and thus postpones any action on proposed health legislation—until after the election!

* * *

A postgraduate course on "Modern Treatment of Fractures and Other Traumatic Conditions" will be held at Massachusetts General Hospital, under the auspices of Harvard Medical School, from September 20 to 29, 1948. This course is covered by the GI Bill of Rights. For further information write Assistant Dean, Courses for Graduates, Harvard Medical School, 25 Shattuck St., Boston, Mass.

* * *

Ernest B. Howard, M.D., has taken up his duties as assistant secretary of the American Medical Association. Dr. Howard was graduated from Harvard College and Boston University Medical School, 1936, and from Harvard School of Public Health, 1941. He served as director of the Division of Venereal Disease in the Massachusetts Department of Public Health, and during most of the war he acted as assistant director of the Division of Venereal Diseases in the Surgeon General's Office, U. S. Army. Since December, 1945, Dr. How-

(Continued on Page 800)

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(Continued from Page 798)

ard has been director of the Health Mission to Peru, South America, of the Institute of Inter-American Affairs within the Department of State. All success, Dr. Howard, in your new duties.

* * *

The Genesee County Medical Society has endorsed a Red Cross plan to establish local blood donation centers throughout Michigan, and has offered its co-operation and services in setting up such a center in Flint, to serve the three major hospitals of that city. This project is designed to take up a serious deficiency in the amount of plasma in Michigan, since it is being used faster than it is being donated.

* * *

Veterans Administration desires the services of full-time and part-time physicians in its regional offices. In the employment of part-time physicians, other than specialists, the services of comparatively recent medical graduates—veterans preferred—are being sought. For further information write Peter A. Volpe, M.D., Branch medical director, Veterans Administration, 52 S. Starling St., Columbus 8, Ohio.

* * *

"*A horse can't pull* while kicking,
"This fact I merely mention—
"And he can't kick while pulling,
Which is my chief contention."

"Convert kicking into pulling and the county society will have an active and energetic worker."—Medical Society of the State of Pennsylvania, Public Relations Newsletter of June 6, 1948.

* * *

E. F. Sladek, M.D., Traverse City, president-elect of the Michigan State Medical Society, was keynote speaker at the opening session of the two-day school for food and beverage handlers of Grand Traverse-Leelanau counties, held in Traverse City May 29-30. Seven hundred and thirty-eight food handlers from the region attended the course. Dr. Sladek is chairman of the Community Health Committee of the Traverse City Chamber of Commerce.

* * *

Senate Committee to Study Health Problems.—The Senate Committee on Labor and Public Welfare is directing its Subcommittee on Health (Senator Smith, Chairman) to continue its study of the health problems of the nation and be able to report on March 15, 1949. The Subcommittee is authorized to develop a research staff and to hold hearings. An amount of $10,000 from the contingent fund of the Senate is allowed to cover expenses. Because of this decision the Committee will not submit a report at this time on S.1320 and S.545.

* * *

Holy Cross Hospital, Detroit.—The annual staff stag party of Holy Cross Hospital was held at Lochmoor Country Club on Wednesday, April 21, 1948. Approximately forty members of the staff were present.

The second annual golf tournament of Holy Cross Hospital was held at Lochmoor Country Club on May 26,

(Continued on Page 802)

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(Continued from Page 800)

1948. The winner of the Chief of Staff Trophy was Dr. William Yott, winner for the second successive year.

Winner of the President's trophy, Kicker's Handicap, was Dr. Edward Krass. Winner of the main door prize, Dr. William Flora.

* * *

Rebates and Kickbacks, Old Stuff—1850.—At the third annual meeting of the Medical Society of the State of Pennsylvania held in Philadelphia, April 17, 1850, the following resolution was adopted: "That this Society regard all collusion between physicians and apothecaries, whether with a view to pecuniary profit or patronage, as opposed to every principle of that moral code which the profession has adopted for its government; and that no physician known to be guilty of such collusion, should be entitled to the confidence and professional intercourse of medical men."

* * *

Advance registration will save your time.—At the MSMS Annual Session, the registration desk will open Tuesday, September 21 at 1:00 p.m. This pre-convention registration is for the convenience of those doctors of medicine who desire to avoid waiting in line Wednesday morning—and perhaps missing a portion of the first lecture (by Frank H. Lahey, M.D., Boston). Doctors who register Tuesday afternoon will be given instant service, without a moment's wait.

If possible, register Tuesday afternoon, September 21, between the hours of 1:00 and 5:00 p.m., and save your time.

* * *

The Ingham County Medical Society's Executive Committee approved the following report of its Public Relations Committee, submitted on April 6:

1. Panel system for emergency calls discarded.
2. Efforts to establish better press relations, telephone listing revision, and other methods to be used instead.
3. Inter-professional Committee to have further study.
4. Scientific programs of the Society to be released, after editing, to the STATE JOURNAL.
5. Radio releases to WJIM, WILS, WKAR.
6. Probst Drug Co.'s "Drama of Medicine" over WILS, 6:15 on Thursdays—to be edited by PR Committee.

* * *

V.A. will release to physicians who are treating veterans the syphilis records of those army personnel who were treated for this disease while in active service—provided authorization for the release of the data is given by the veteran-patient. Details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records. Requests for the résumé, plus the authorization from the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munitions Building, Washington 25, D. C. Be sure to include the veteran's service serial number and other identifying information (such as the date of

(Continued on Page 804)

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(Continued from Page 802)

enlistment, the date of discharge, rank, and organization). The résumés will be furnished in approximately two weeks from date of receipt of request and the signed authorization.

* * *

Seek Data on Child Accidents.—The Metropolitan Life Insurance Company, which has done considerable advertising in the interest of the nation's health, is now focusing attention on the problem of accidents in the pre-school age group as a major cause of mortality.

The company is interested in county medical societies which have taken action in accident prevention to the extent of creating an accident committee or of making some other committee responsible for study of accidents and their prevention.

The AMA Bureau of Health Education is trying to procure information for the company. The Bureau would appreciate any information pertaining to county medical society accident prevention committees or activities.

* * *

The Kalamazoo Academy of Medicine at its Board of Directors meeting of May 26, adopted the following rules for hospital emergency service:

Emergency Service

The physicians and hospitals of this community are prepared to provide emergency service to the public on the following basis:

1. Hospital emergency service is maintained to save life. Minor injuries or illnesses should be cared for in a doctor's office.
2. Hospital nurses will assist the patient to obtain medical care by calling the patient's own doctor.
3. In case the patient has no doctor, or his own doctor cannot be reached, the nurse will summon the doctor on emergency call.
4. While awaiting a doctor's orders, nurses are only allowed to give first aid.

* * *

The Statement.—"We, the members of the Indianapolis Medical Society, do hereby resolve that the welfare of the medical profession, its scientific advancement and the furtherance of public interest are continuously being harmed by organizations which demand compulsory attendance of physicians at meetings.

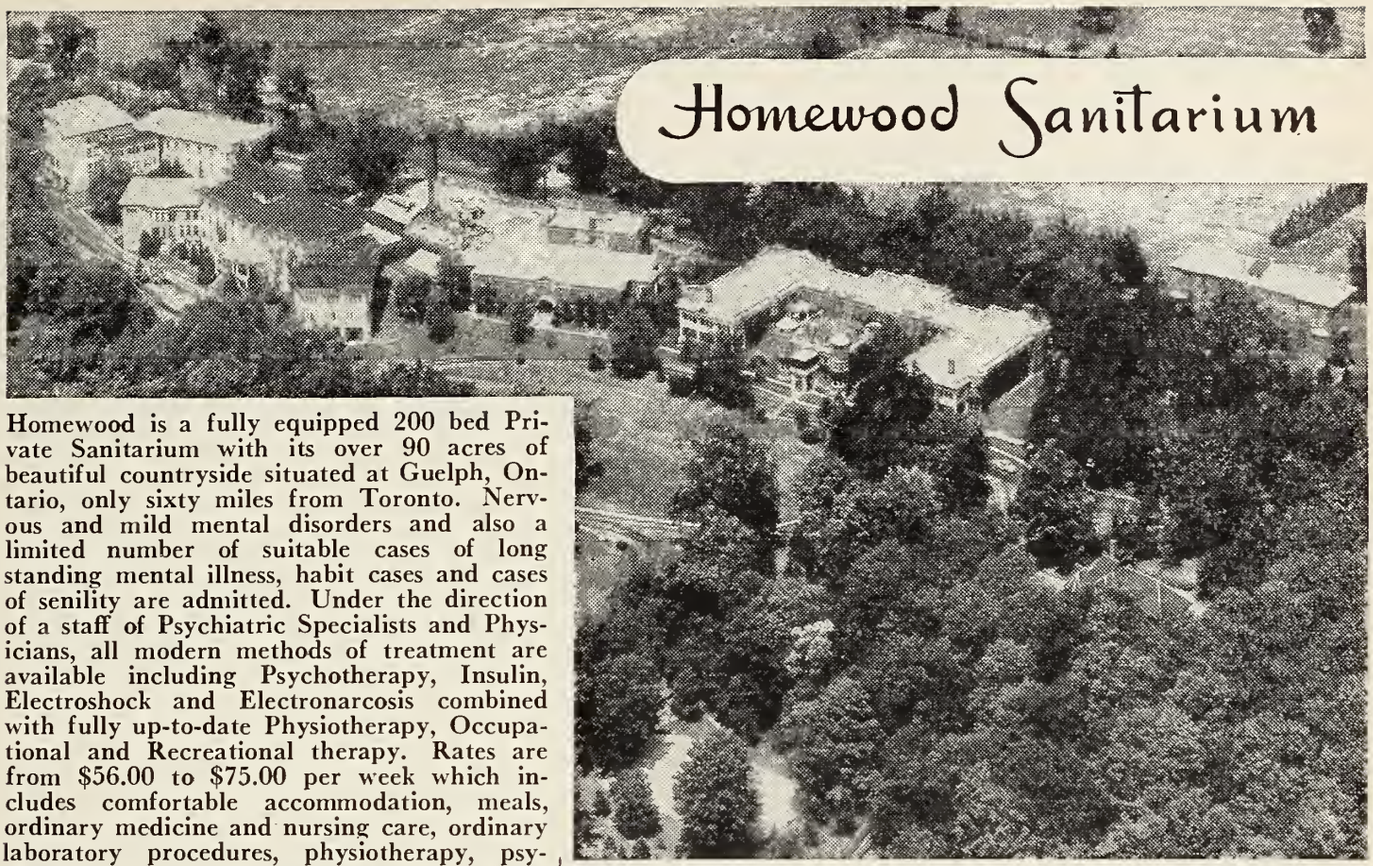
"To this end we instruct our duly elected delegates to the Indiana State Medical Association to introduce proper measures at the next meeting of the House of Delegates to the effect that all organizations which require compulsory attendance at their meetings no longer be approved by the American Medical Association; and, we further instruct our delegates to use their utmost influence to obtain passage of such a resolution at the earliest opportunity before the House of Delegates of the American Medical Association.

"The Indianapolis Medical Society furthermore instructs its secretary to send a copy of this resolution to every component Medical Society in the United States."

* * *

Living Costs Rise Faster Than Doctors' Fees.—In his new study entitled "Comparative Increases in the Costs

(Continued on Page 806)



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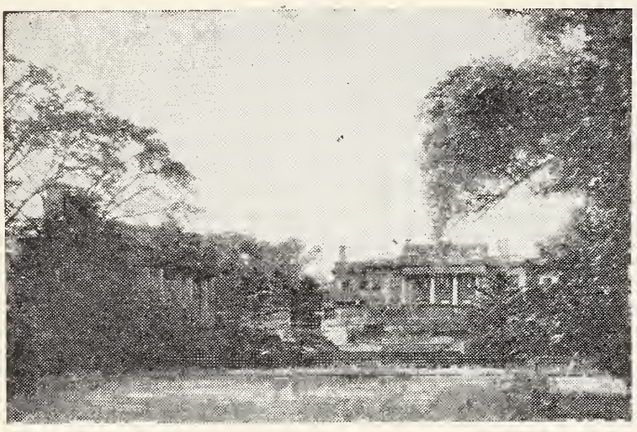
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(Continued from Page 804)

of Medical Care and the Costs of Living," just off the press, Frank G. Dickinson, Ph.D., director of the AMA Bureau of Medical Economic Research, reports that the cost of living has risen more rapidly than the fees charged by physicians for medical services.

He found that the quantity of medical care received by the American people was at least two thirds more in 1946 than in 1939.

"When the various indexes and ratios are studied," Dr. Dickinson said, "it can be seen that the quantity of medical care received by the American people has probably increased much faster than the increase in the number of physicians. This apparent 'output' per physician doubtless reflects the increasing use of technical assistants.

"Whether one examines the record of total expenditures of the American people for medical care or the prices of significant items during recent years, he comes to the general conclusion that the American people have been fortunate in that the costs of keeping well have not risen as rapidly as the cost of living."

* * *

Rules and Regulations for Cancer Detection Centers.—

1. These Clinics shall be for educational and screening purposes only.

2. There shall be no distinction between indigent or non-indigent patients. On an educational basis, this is only a problem of referral; the non-indigent are sent to private physicians, the indigent to tumor clinics or other organizations set up to provide medical care for this group.

3. Examination shall be the same in all hospitals.

4. The examination shall only consist of:
   (a) Complete history and a physical examination.
   (b) There shall be no laboratory work.

5. There shall be no treatment given at any of these clinics.

6. The present title "Cancer Detection Clinic" is a misnomer and shall be changed to "Cancer Detection Center" or "Cancer Center."

Approved by the Council, Wayne County Medical Society, May 17, 1946.

* * *

Navy's New Medical Training Program.—The Surgeon General of the Navy has announced the expansion of the Bureau's professional training program for reserve and regular medical officers, which is similar to the recently expanded Army medical training program. The object is to permit more Navy doctors to meet the requirements for certification by the various American Specialty boards, and to encourage the young doctor to intern under the auspices of the Navy. The following are the important points in this program:

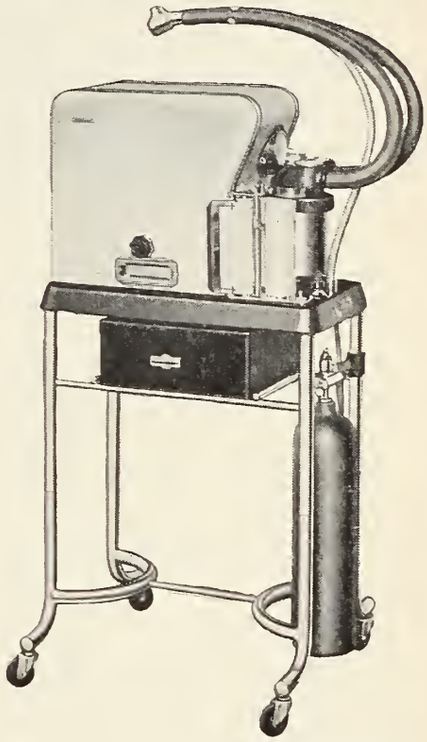
Graduates of Class A medical schools who have been accepted for internship by a hospital approved for such training by the Council on Medical Education and Hospitals of the AMA may be commissioned as lieu-

(Continued on Page 808)

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$20,000.00 accidental death *$100.00 weekly indemnity, accident and sickness*	**$32.00** *Quarterly*

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(Continued from Page 806)

tenants (junior grade), MC, USNR, and permitted to continue their intern training. They will receive all the pay and allowance of the rank while so serving. After completing their internships, the medical officers must remain on active duty for a period of one year. If they meet the professional, physical and moral requirements, they will be given every encouragement to transfer to the regular Navy.

Interns who have completed the one year of obligated service, and who have transferred to the regular Navy, may be considered for residency training on a competitive basis with other officer personnel of the regular Medical Corps.

Resident physicians now in civilian hospitals, or those accepted for approved residency training, are eligible for commissions in the regular Navy. Those so commissioned will be assigned to duty, with full pay and allowances, in the hospital in which they are already a resident, or to which they have been accepted for residency training. Every attempt will be made to permit residents holding commissions in the regular Navy to complete their training in event of an emergency.

The Navy has at the present time 400 approved residencies and fellowships in the various specialties recognized by the American Specialty Boards in Naval and civilian hospitals. This educational training involving the 400 residencies is divided into two programs.

Information concerning these programs may be obtained by writing to Chief of the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

More Orchids About the Michigan Postgraduate Clinical Institute of March, 1948

H. W. Baker, M.D., of Woodstock, Ontario: "As we left Detroit on the Friday evening, I asked the men in my car what they thought of the Clinic, and we were all agreed with the answer that it was the best we had ever attended. The hospitality given us by the Michigan men was beyond compare, and we all hoped that we would be given an early notice of the next meeting of the Institute in the spring of '49, because we all intend to go back. We thank you very much for the privilege of attending this conference."

Kenneth Murray, M.D., Hamilton, Ontario: "I should like to thank the Michigan Postgraduate Clinical Institute for the excellent continuation course I attended last March. I want to thank you for extending your facilities to us Canadians and to tell you I shall be on hand again next spring. I enjoyed all the program, probably the surgical subjects more as I am a general surgeon. Of course I realize that all branches of medicine must be represented. Especially worth while was the symposium which took place in the evening. Again please accept my thanks for your kind invitation for March, 1949."

C. W. Pennecott, M.D., London, Ontario: "It was indeed a pleasure and a privilege to attend your Michigan Postgraduate Clinical Institute Meeting in March. All of our group of four enjoyed your papers and your wonderful hospitality so much, that we determined, if possible, to make our attendance at your meetings an annual affair. May we hope to see the friendly asso-

(Continued on Page 810)

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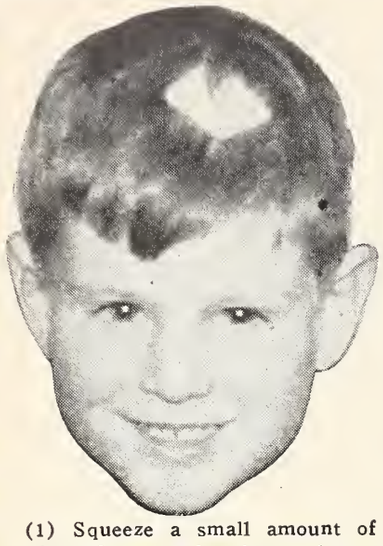
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OPHTHALMOLOGY—Intensive Course, two weeks, starting September 20.
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Ocular Fundus Diseases, one week, starting November 15.
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(Continued from Page 808)

ciation enjoyed by Americans and Canadians on our respective visits to each other's countries grow until it embraces all the Nations of the world? How welcome a change from the present, useless conflict. I wish again to express my appreciation for your kind invitation to Canadians to attend and enjoy your outstanding annual meetings."

J. C. Boyce, M.D., Fremont, Ohio: "I enjoyed the meeting very much, especially because there was so much practical material that is of use to the man in general practice. Usually with most medical meetings one attends these days the material presented is very technical and of little use to the general man. Thank you for your kind invitation; I expect to attend again next year."

E. Grant Berry, M.D., Merlin, Ontario: "The idea back of the Michigan Postgraduate Clinical Institute is very praiseworthy, while the presentation, arrangements and commercial displays were very much worth while, even down to the courtesy and cheerful manners of the attendants. The whole thing, from start to finish, was very enjoyable and instructive. Please be sure that my name is on your list for next year."

H. S. Dunham, M.D., Toronto, Executive Secretary, Ontario Medical Association: "We seek the inclusion of the Ontario Medical Association name on your mailing list for advance information on your future postgraduate meetings."

A. G. Volpe, M.D., Toronto, Ontario: "I would greatly appreciate if you would kindly put me on your mailing list for your next annual Clinical Institute."

NEWER CONCEPTS IN THE DIAGNOSIS OF THE GLAUCOMAS

(Continued from Page 728)

diagnosis of glaucoma simplex possible, since it is the most important ocular disease in relation to blindness, and one whose ravages can be prevented to a large extent by early recognition.

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Say you saw it in the Journal of the Michigan State Medical Society

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

IDENTIFICATION OF TUMORS, ESSENTIAL GROSS AND MICROSCOPIC PATHOLOGIC FEATURES SYSTEMATICALLY ARRANGED FOR EASIER IDENTIFICATION. By N. Chandler Foot, M.D., Professor of Surgical Pathology, Cornell University Medical College; Surgical Pathologist to New York Hospital. 241 Illustrations. Philadelphia: J. B. Lippincott Co., 1948. Price 6.00.

This is a small book designed to give the essentials of diagnosis of tumors without the necessity of grinding through long complicated works. It is especially for students and younger practitioners. The tumors are considered in the various sections or parts of the body, are systematically described as to source, age and sex, signs and symptoms, gross appearance, microscopic appearance, malignancy, differential diagnosis and metastasis. Pathological sections abound, sometimes several for a single tumor. Methods and materials are explained, making the book especially valuable.

TREATMENT IN GENERAL PRACTICE. By Harry Beckman, M.D., Professor of Pharmacology, Marquette University School of Medicine, Milwaukee, Wisconsin. Sixth Edition. 1129 pages. Philadelphia and London: W. B. Saunders Company, 1948. Price $11.50.

The teaching of therapeutics is made much more systematic and thorough by study of this text. It is in its sixth edition, which speaks well for the author and the acceptance of his work. The author believes that the art of diagnosis does not carry with it the ability to treat. The latter is a study and enterprise in itself. He claims to be an editor, presenting the material of a host of authors who are mentioned in an entensive bibliography. The subject matter, in general, is presented alphabetically in mentioning the infectious diseases, after which are fluke infestations, worm infestations, allergic diseases, deficiencies, endocrines, and diseases according to systems. The index is profuse. The work is a complete guide for therapeusis of practically all medical conditions.

PHYSIOLOGY OF EXERCISE. By Laurence E. Morehouse, Ph.D., Associate Professor of Physical Education, The University of Southern California; Formerly Research Fellow, Harvard Fatigue Laboratory; and Augustus T. Miller, Jr., Ph.D., Associate Professor Physiology, University of North Carolina Medical School. Illustrated. St. Louis: C. V. Mosby Co., 1948. Price $4.75.

A study of the reactions of the human body to exercise, and to certain stresses, is an outgrowth of the war period and experience. Muscle contractions and their effects, the use of oxygen in exercise, factors of the speed of recovery from exercise, cardiac output, regulation of the stroke, volume of blood in circulation, every imaginable form of effort and exercise are studied, and their effects



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on the good condition of the human body are noted. Much of the book is devoted to the heart and circulatory system, but the pulmonary system is just as important, and both are studied in regard to every effect of breathing, moisture, volume of air, regulation of respiration. The kidneys are not forgotten. In fact, this is a compact but complete text for athletics and athletes.

SYNOPSIS OF PEDIATRICS. By John Zahorsky, A.B., M.D., F.A.C.P., Professor of Pediatrics and Director of the Department of Pediatrics, St. Louis University School of Medicine, and Pediatrician-in-Chief to the St. Mary's Group of Hospitals; Fellow of the American Academy of Pediatrics; Assisted by T. S. Zahorsky, B.S., M.D. Senior Instructor in Pediatrics, St. Louis University School of Medicine, and Assistant Pediatrician to the St. Mary's Group of Hospitals. Fifth Edition, with 158 Text Illustrations and 9 Color Plates. St. Louis: C. V. Mosby Co., 1948. Price $5.50.

As indicated in the preface, this book is a summary. Used for that purpose it should continue to be of value to the student and to the practitioner. While of necessity the work is considerably condensed, it does provide the essential information concerning the diseases of children ordinarily presented to the family doctor.

It should provide the general practitioner with a source of quick authoritative information concerning pediatric conditions.

The book does not presume to give a complete discussion of any condition, reserving that particular field to the larger recognized textbooks.

The fifth edition has been considerably revised, especially concerning treatment. This has necessitated enlarging the volume, and also deletion of some older material.

H. F. B.

OSTEOCHONDRITIS DISSECANS AND OSTEOCHONDROMATOSIS

(Continued from Page 736)

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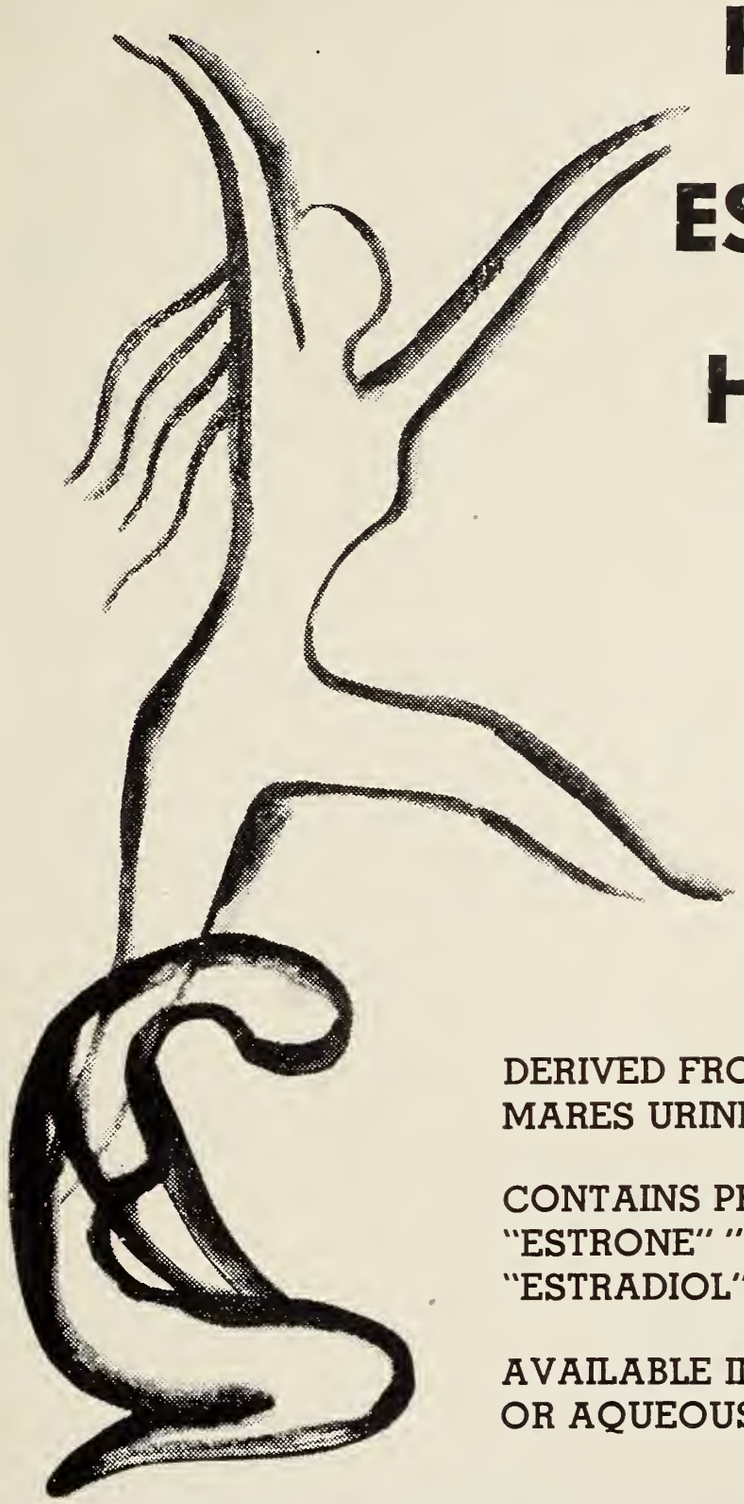
(Continued from Page 750)

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Cancer Comment

THE DETROIT CANCER CENTER

An event of more than local significance occurred on April 20, 1948, when the Detroit Cancer Center was formally dedicated. The remodeled building at John R and Hancock Streets will serve all the cancer activities in the metropolitan Detroit area as well as provide laboratory space for the Detroit Institute of Cancer Research.

The building is owned by the Michigan Cancer Foundation, a nonprofit organization acting as trustee for contributions to those phases of the cancer control program that do not fall within the scope of the American Cancer Society's activities. Already, substantial sums have been given for preparing the building for its present uses, among them that of the Variety Club composed of motion picture theatre owners and operators whose assistance was recognized by the unveiling of a plaque in its honor at the dedicatory ceremonies.

The Southeastern Michigan Division of the American Cancer Society, representing, Macomb, Oakland and Wayne Counties, will have its headquarters in the building for carrying on its extensive educational and service programs. Under auspices of this organization eight cancer detection centers are operating in various Detroit hospitals and it is intended to open an additional center in the new headquarters in the near future.

The Center will also furnish facilities for an enlarged lay and professional educational program in a meeting room with a capacity of 200 or more. At the dedication ceremonies it was announced that next October a three-day cancer institute would be offered to the medical profession of Michigan and adjoining areas.

The Detroit Institute of Cancer Research will occupy quarters on the second floor where space is available for twenty-five workers. The research program which has been under way for several years in temporary quarters provided by Wayne University Medical School, has been focussed on some of the biological problems concerned with cancer etiology. Ample quarters are available for laboratory animals and it is the present intention to devote some time to breeding animals of definite biological strains for controlled cancer experiments. Laboratories will be equipped for isotope and biophysics studies.

Organization of the Detroit Institute of Cancer Research in 1942 was due to the energy and vision of the late Rollin H. Stevens, M. D. whose specialty of radiology threw him in close contact with the cancer problem for many years. He felt the definite need for additional facilities for cancer research and devoted the last years of his life to developing the idea of such a research center in Detroit. Due to the war it was impossible to proceed with plans for a permanent home for the Institute during his lifetime. The present building and the activities it houses will be a fitting memorial to his untiring interest in the problem of cancer research and control.

The Detroit Cancer Center is probably the first institution of its kind to emerge from the greatly expanded co-operative program that has been developed in the last few years between scientific and lay individuals and groups. It is planned to co-ordinate its research program with the larger program on cancer research now supervised by the National Research Council and subsidized by the American Cancer Society. Nearly 200 research projects are being studied in this co-ordinated program which is devoted, in the main, to investigation of the biological and physical factors concerned with the process of growth.

LYMPHOID TUMORS

Lymphoid tumors if untreated will invariably result in the death of the patient. The onset of the disease is insidious. Enlargement of the lymph nodes of the neck —the first symptom—frequently follows an upper respiratory infection. Symptoms include weakness, fatigue, loss of weight, and pain which is indicative of advanced disease. Ten per cent of the patients show bone involvement.

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2. Before you telephone your doctor, make a list of the questions you want to ask him. Have a paper and a pencil handy when you call, so that you may take down his instructions. This way you will save your doctor's time, and remember *accurately* what he tells you.

3. Answer your doctor's questions *fully*. A previous illness may not seem to you to have any bearing on your present condition. But to your doctor it might furnish a valuable clue. Tell him complete facts. Let *him* decide what is important.

4. Follow your doctor's instructions *exactly*. If he prescribes medicine, take it *according to directions*. Remember, a larger dose than that prescribed won't cure you faster. And it might be harmful.

5. Never use medicine prescribed for somebody else, or for a previous illness of your own. However similar your symptoms may appear to you, the nature of your illness may be quite different. Only your doctor can accurately diagnose your trouble and prescribe proper treatment.

6. If your doctor advises an operation, don't put it off. With modern surgery, modern bospital care, you seldom have reason to fear an operation.

7. The new medical treatments you read about in the popular press aren't likely to be news to your doctor. If your doctor has not recommended a new treatment to you, it is probably because there are still some questions about its value, some limitations not stressed in popular reports, or some factors in your case which would make the treatment undesirable or ineffective for *you*.

8. Don't ask your doctor to advise you about members of your family whom he himself has not seen. He cannot risk giving an opinion about a patient of whose condition he bas no firsthand knowledge.

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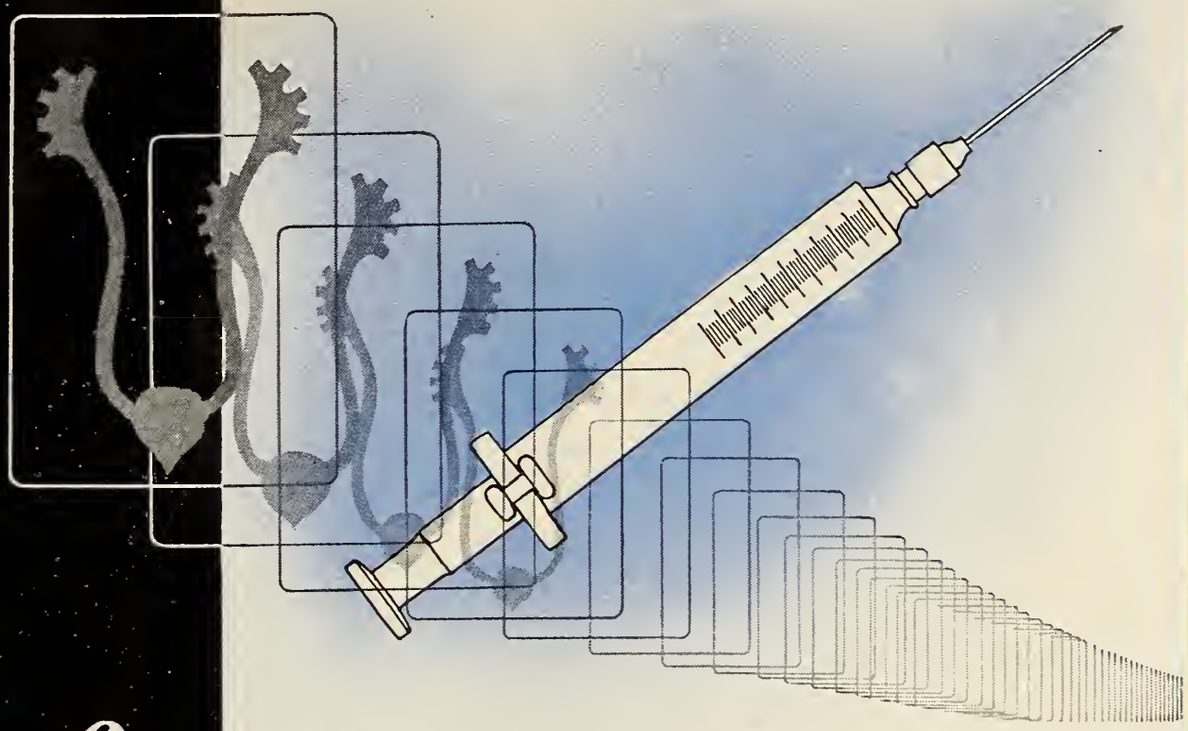
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J. C. Tapert, Detroit; G. A. Tatelis, Detroit; Aaron Taylor, Detroit; John Ten Have, Grand Rapids; William J. Thaler, Detroit; Daniel C. Thomson, Ann Arbor; Ledyard H. Tomlinson, Newport; K. W. Toothaker, Lansing; H. A. Towsley, Ann Arbor; Bryan Trombley, Detroit; F. L. Troost, Holt; Paul K. Truba, Detroit; Keith M. Truemner, Detroit; S. W. Trythall, Detroit.

R. W. Ullrich, Mt. Clemens.

R. S. Van Bree, Grand Rapids; T. P. VanderZalm, Lansing; James E. Van Eck, Detroit; Frank Van Schoick, Jackson; J. D. Van Schoick, Hanover; Edward M. Vardon, Detroit; H. E. Vergosen, Detroit; Edward E. Vivirski, Jackson; Milton D. Vokes, Detroit; Heide E. C. Vonder, Detroit.

R. W. Waggoner, Ann Arbor; Perry V. Wagley, Pontiac; Everal M. Wakeman, Dearborn; Irving A. Warren, Detroit; John E. Webster, Detroit; John H. Welch, Detroit; Martha Wells, Detroit; J. F. Wenzel, Detroit; Charles J. Westover, Plymouth; A. H. Wittaker, Detroit; Harold W. Wiley, Lansing; Harry E. Windiate, Pontiac; Andrew G. Wilson, Detroit; William G. Winter, Holland; Joseph A. Witter, Detroit; Lance S. Wright, Wayne; Charles A. Wunsch, Detroit.

Arthur J. W. Yates, Detroit; J. P. Yegge, Kent City.

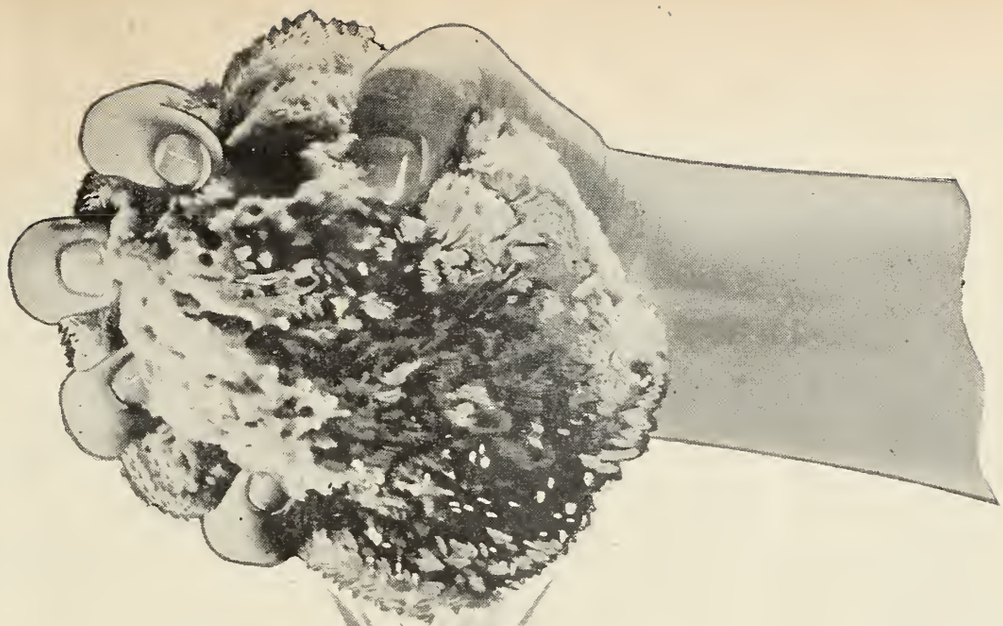
Registrations for March 12, 1948

Sidney L. Adelson, Detroit; Allen Alexander, Detroit; C. P. Anderson, Eloise; H. B. Appelman, Detroit; James W. Armbruster, Detroit; Lawrence R. Atler, Detroit; LeRoy L. Atler, Detroit; Ira Avrin, Detroit.

Arthur G. Baker, Allegan; C. D. Barrett, Eloise; S. K. Beigler, Detroit; J. E. Berry, Detroit; G. A. Brough, Detroit; Samuel M. Brown, Detroit; Loren G. Burt, Flint; Harry J. Butler, Detroit.

L. C. Chang, Northville; C. P. Clark, Flint; Donald V. Clark, Detroit; George J. Curry, Flint; John M. Czuj, Detroit.

(Continued on Page 594)



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Senator Vandenberg Tells Premier Stalin



At the Michigan Congressional Dinner in Washington on April 26, Senator Arthur H. Vandenberg said he wanted to tell Premier Stalin of Russia that "underlying everything else we shall not surrender to Communist conspiracies in the United States."

"We are suicidal fools if we do not root out any treason at home which may dream of bringing world revolution to the United States. The United States cannot accept a Munich peace because appeasers merely precipitate the very disasters from which they seek to flee."

While reiterating the Nation's desire for peace, Senator Vandenberg said: "We are realists. We do not propose to be isolated in a world that has been communized by force."

Senator Vandenberg remarked that a lasting peace must be based on justice and freedom and must protect the survival of western civilization. While the United States does not covet an inch of territory or a dollar of reparations, he said, it responds with its resources to help other nations who believe in the democratic way of life and are in need.

The Senator emphasized the United States' willingness to co-operate with Russia in achieving a just peace, but he said "We cannot be driven or coerced into positions we decline to assume."

This nation, he added, will not bargain with human rights and fundamental liberty.

At the dinner, given in honor of Senators Vandenberg and Ferguson and Michigan's seventeen Congressmen, the Michigan State Medical Society was represented by L. Fernald Foster, M.D., Bay City, L. W. Hull, M.D., Detroit, and R. J. Hubbell, M.D., Kalamazoo. The Wayne County Medical Society was represented by C. L. Candler, M.D., Detroit, and the Bay County Medical Society sent A. D. Allen, M.D., Bay City.

An interesting sidelight of the dinner was the enthusiastic meeting of Senator Ferguson by Mr. Lowell B. Genebach of Battle Creek. Mr. Genebach introduced himself to the Senator as the father of Ferguson's first appointee to West Point in 1944.

Senator Ferguson stated, "I am glad to meet the father of my first appointee, but I have yet to meet the appointee."

Selections to West Point are not political in Senator Ferguson's book.

Attendance 1948 P.G. Institute

(Continued from Page 592)

M. J. Dardas, Bay City; G. E. Davidson, Detroit; Geo. C. DeSmyter, Detroit; Max E. Dodds, Flint; Donald Drolett, Ann Arbor; John J. Dudek, Detroit; F. W. Dwyer, Detroit.

A. F. Fath, Kalamazoo; F. S. Fordell, Detroit; Merle S. French, Paw Paw, A. C. Furstenberg, Ann Arbor.

David B. Gaberman, Detroit; Watson A. Gilpin, Detroit; Samuel Gingold, Detroit; Wm. S. Gladstone, Flint; F. Gordon Grant, Detroit.

A. J. Hamilton, Flint; Foster Hampton, Jr., Detroit; Lawrence Harrington, Detroit; F. W. Hartman, Detroit; Louis E. Heideman, Detroit; Horace B. Holloway, Detroit; Henry T. Holt, Grosse Pointe Woods; George B. Hoops, Detroit; Harold A. Horkins, Detroit; Philip J. Howard, Detroit; W. L. Howard, Northville.

J. F. Jellema, Detroit; F. N. Johnson, Detroit; R. E. Johnson, Flint; W. H. M. Johnson, Detroit; W. S. Jones, Menominee.

Mana Kessler, Bay City; H. F. Kilborn, Ithaca; Walter W. Kitti, Detroit; Lewis L. Kline, Detroit; M. D. Klopfenstein, Northville; M. E. Kohn, Detroit.

M. L. Lichter, Melvindale; A. G. Liddicoat, Detroit; James Lousell, Detroit.

G. T. McKean, Detroit; James J. McClendon, Detroit; Richard M. McKean, Detroit; Kenneth E. Mapletoft, Detroit; M. H. Marks, Detroit; K. E. Markuson, East Lansing; Robt. J. Mason, Birmingham; Richard H. Meade, Jr., Grand Rapids; George Mogill, Detroit; F. L. Morris, Cass City; H. L. Morris, Detroit; Charles Wayne Moulton, Detroit; A. P. Murphy, Saginaw; John M. Murphy, Detroit; Paul H. Muske, Detroit.

John M. Nehra, Detroit.

Charles Patrick, Pontiac; J. P. Pratt, Detroit; Hazen Price, Detroit.

Hugh Robins, Battle Creek; D. L. Rousseau, Detroit.

Jack F. Sanders, Detroit; R. J. Sadowski, Detroit; G. E. Sands, Detroit; Donald Schiff, Detroit; B. W. Schmidt, Detroit; Graham Sellers, Detroit; Milton Shaw, Lansing; Herbert L. Shroyer, Detroit; Robert Simpson, Battle Creek; J. Campbell Smith, Bay City; M. M. Sylvan, Van Dyke.

A. Tauber, Pontiac; Geo. C. Thosteson, Detroit; Franklin H. Top, Detroit.

Henry Van Duine, Grand Rapids.

I. Paul Walker, Grosse Pointe Park; Frank A. Weiser, Detroit; Geo. W. Westcott, Goodrich; Alec Whitley, St. Clair Shores; Stuart Wilson, Detroit; H. C. Wissman, Detroit; Victor Hugo Wolfson, Mt. Clemens.

S. A. Yannhelli, Northville.



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Military Medicine

DOCTORS FOR MILITARY SERVICE

The greatest challenge confronting Congress and the medical profession today is "the proper and adequate provision for the care of the great number of horrible civilian casualties that are promised if World War III is to come."

This statement was made by James C. Sargent, M.D., Milwaukee, before the Armed Services Committee of the House of Representatives in expressing opposition to parts of Section 4 of H.R. bill No. 6274. This bill as now worded would authorize the President, pursuant to requisitions submitted by the armed forces, to draft physicians above the age of 25 stipulated as basic in the proposed law.

"To give to the Military Establishment carte blanc as this bill proposes to do, would surely lead to the same over procurement of medical personnel as before," Dr. Sargent said. "And if another war is to come—biologic and atomic warfare this time—large disaster areas with terrible civilian casualties must be expected and must be adequately provided for if the Nation is to survive.

"Ordinary civilian pursuits, agriculture and especially industry—the very foundations of our national war strength—will never survive the high casualties in store for them in another war if civilian doctors are to be thinned down again to the one to 1,500 ratio that was reached during the last war.

"The special provisions in Section 4 (c) and (d) of H.R. 6274 set the pattern for just an unsafe distribution of physicians and set the stage for just such a national catastrophe."

Dr. Sargent is chairman of the American Medical Association's Council on National Emergency Medical Service. With but one exception, eight of the nine members of the Council, including Dr. Sargent, served in the Armed Forces during the recent war. The other member served as one of the five directors of the Procurement and Assignment Service, the agency through which 60,000 civilian physicians were recruited during World War II.

The Armed Services Committee of the House of Representatives were told that a survey made by a special committee of the A.M.A. of some 50,000 doctors revealed:

1. There were far more civilian physicians procured for the armed services during World War II than were effectively needed or used.

2. The subtraction of this large group of physicians from the civilian population left a shortage that was dangerously acute and sorely noticed despite the remarkably healthy state of the nation throughout the war years.

"A national tragedy would surely have occurred had we experienced an influenza epidemic like that following World War I or had we suffered civilian war casualties such as the bombed countries of Europe experienced in World War II," Dr. Sargent said.

The Council chairman added that "if the nation is to survive another war there can be no brooking the waste of medical talent that prevailed in the Army, Navy and Air Force throughout the war just passed." Happily, he said, the Military Establishment, from the Secretary of Defense down, is working toward far better use of the medical personnel and facilities of the three services.

The studied belief of the Council on National Emergency Medical Service and the Board of Trustees of the American Medical Association, stated Dr. Sargent, is that a special provision in the law for the drafting of doctors is "both unnecessary and unwise."

Because of the accelerated program of medical education carried on during the war years, doctors are graduating today well under the age of twenty-six. Through this circumstance, doctors made available under the general draft provisions of H.R. 6274 would be wholly adequate to meet the numerical requirements of Medical officer personnel for the increased strength of the armed forces authorized in the bill."

The point is raised, and properly so, that this would furnish only young, recently graduated physicians. That there is need for some older physicians of special talent is obvious. Such need cannot be great, however, considering the fact that this bill provides for a peace time expansion of the armed forces that does not contemplate heavy casualties of war and, important to note, provides for the medical care of young men in the prime of life and hand picked for their physical fitness.

"There are other ways, less onerous than this proposed legislation, to provide the expert services of experienced physicians and surgeons needed for the expanding Army, Navy and Air Force. The Veterans Administration has pioneered in the use of highly skilled specialists in civilian practice as part-time consultants and the unprecedented excellence of the care that is being given veterans today under such a system merits the serious notice of the Military Establishment.

"Today each city of size in America holds able and thoroughly experienced specialists of every category who are not too deeply rooted to consider rejoining the military as a career were such service made somewhat more attractive. But they recall the barrier that age played against obtaining rank and pay that was commensurate with their exceptional talents. And they recall the withering experience of long periods of inactivity and of non-medical duties."

Doctors, both in and out of service must have clinical medical work to challenge their abilities and keep them professionally alive. While there are certain real inducements to attract able medical talent to a career in military medicine they simply are not enough. Purely administrative changes, dealing with rank and duty assignment, could and would over night minimize the

(Continued on Page 598)

PROTEINS...

Pre- and Post-operative



"Surgical patients in many instances tend to come to operations in a depleted state. There are many reasons for this: chronic gastro-intestinal disease . . . long-standing infectious processes . . . or loss of blood. The preparation of the patient for surgery includes nutritional preparedness. In the first instance, this means a good supply of *proteins* and carbohydrates.

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You and Your Business

WARNING ISSUED ON CONTAMINATED DEXTROSE SOLUTION

A warning to all physicians and hospitals to check their stocks of Cutter's dextrose and saline solution bearing code number CM 8164 was issued today in an editorial which will appear in the May 1 issue of *The Journal of the American Medical Association.*

The editorial states in full:

"On April 19 the Headquarters of the American Medical Association received a wire from Dr. W. F. O'Donnell, Jr., of Hazard, Kentucky, reporting serious reactions in two patients immediately following the intravenous use of five per cent glucose in normal saline manufactured by Cutter Laboratories, Berkeley, California. The American Medical Association immedately notified the Food and Drug Administration of these facts and a nationwide investigation by Federal and State regulatory officials was launched. Not all of the facts are yet available but the following information justifies a warning to all physicians and hospitals.

"At least two and possibly four deaths have occurred in Miami, Florida; Lexington and Louisville, Kentucky, following administration of Cutter's dextrose and saline bearing code number CM 8164. At least eight other serious reactions have been reported, mostly from southern communities. Several hundred one liter bottles with this code number are unaccounted for and the firms shipping records are so incomplete as to make it impossible to trace and recover all of the outstanding material quickly. Although the contaminant has not been identified, it appears to be a heavy growth of bacteria or mold. Many of the unopened bottles show a distinct cloudiness.

"Physicians and hospital officials are urged to check their stock for this code of five per cent dextrose in saline, and if any is found to hold it and notify the nearest office of the Food and Drug Administration which is working at top speed to recover all outstanding material. The Food and Drug Administration requests that none of this product be destroyed in order that an accurate check on the extent of recovery of this dextrose solution can be made.

"This unfortunate incident again emphasizes the necessity for prompt notification of the American Medical Association and the Food and Drug Administration of any suspicious or unexpected reaction following the administration of a drug. Quick action by Dr. O'Donnell in notifying the Association of the reactions in his patients has no doubt saved the lives of many other persons. As yet Cutter Laboratories has offered no explanation of why this contamination was not detected before the product was distributed. The medical profession is entitled to know the facts in this case and to be assured that the drugs they purchase are safe."

CROCODILE TEARS

Oscar R. Ewing, federal security administrator, wound up his stacked seminar to promote the Truman program of state medicine with the announcement that private endowments of medical institutions were drying up and that the federal government therefore would have to subsidize them. About 800 handpicked delegates were invited to Washington for the meeting, but it was disclosed that Ewing had the supposed "report" of the conference half written before they got there.

The security administrator did not choose to examine the reasons why medical schools and hospitals are running into financial trouble. All he needed to do was look back over 15 years of New Deal tax rates to find the reason. Income and estate taxes have been at such confiscatory levels that private donors no longer have the wherewithal to support these and all other kinds of philanthropic institutions.

Ewing's solution is the usual New Deal prescription: The government will fill the gap by siphoning public money into the institutions whose sources of support have been dried up by the same government. In doing so, it will perpetuate if not aggravate the situation over which Ewing weeps by maintaining or increasing the tax rates to produce the new money to go into the institutions.

From the New Deal viewpoints, the scheme works out nicely. Government will further extend its encroachments upon another field of activity which so far has resisted the incursions of the bureaucracy. The cause of socialized medicine will be correspondingly advanced, with the ultimate prospect that the payrollers will take over the whole field of medicine and regiment doctors and the public alike.—Editorial, *Chicago Tribune,* May 9, 1948.

ONE-THIRD OF A NATION

More than one-third of the nation's population has received or is entitled to Federal veterans' or dependency benefits, the Veterans Administration says.

This total includes an all-time high of 18,733,000 living veterans of all wars, plus their dependents and the dependents of deceased veterans.

There are 14,870,000 living World War II veterans.

The VA estimated that by June 30 veterans and their dependents would total 52,300,000, comprising 36.5 per cent of the nation's 143,300,000 population.

By June 30, 1955, this group will reach 60,100,000, or 40.1 per cent of the population, the VA said. From that point on, the figure gradually will decrease.

DOCTORS FOR MILITARY SERVICE

(Continued from Page 596)

medical personnel problems that so concern the armed services today.

"And in the end, if neither of those means are to be employed and experience proves that soldiers and sailors are in need of medical care the profession of America will see they get it, draft or no draft. They did it handsomely in the last war, as, indeed, they always had before. And they would do it again."

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Political Medicine

THE NATIONAL ASSEMBLY

The National Health Assembly, called by Federal Security Administrator Oscar Ewing at the request of President Truman, to attempt to work out areas of agreement between the various lay groups and the medical profession for a ten-year health program, ended on May 4 with most groups apparently pleased at the outcome of the intensive four days of serious discussion.

The Section on Medical Care was the most active. It consisted of over one-fourth of the 800 delegates (but listed only eighteen practicing doctors of medicine!). The Resolution of Goals introduced by Nelson Cruikshank of the AFL was referred to the Planning Committee which brought in the following conclusion, preliminary to preparation of its final report:

"1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical, mental and social health should be available to all without regard to race, color, creed, residence or economic status.

"2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test."

"3. Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional

a. services to persons or groups for whom special public responsibility is acknowledged and

b. services not available under prepayment or insurance.

"4. Voluntary prepayment group health plans, enbodying group practice and providing eomprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means.

"5. High standards of service, efficient administration and reasonable costs require:

a. Co-ordination of the services of physicians, hospitals and other health agencies in all phases of prevention, diagnosis and treatment.

b. Effective co-operation between the providers and the consumers of such services.

"6. The people have the right to establish voluntary insurance plans on a co-operative basis and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications), now existing in a number of States, should be removed.

"7. A medical care program by itself will not solve the health problems of the Nation. It must be co-ordinated with all efforts directed toward providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation and such other measures as will correct conditions that adversely affect the physical, mental and social health of the people.

"8. There are areas on which the Planning Committee is not yet prepared to report. In the meetings of the Medical Care Section, differing views were expressed as to the method of affectuating the principle of prepayment or insurance. Some believe it can be achieved through voluntary plans. Others believe that a national health insurance plan is necessary."

On the Planning Committee beside Mr. Cruikshank were Chairman Hugh Leavell, M.D., of Harvard, Ernst P. Boas, M.D., of the Physicians Forum, Thomas A. McGoldrick, M.D., Brooklyn, and James R. McVay, M.D., Kansas City, members of the AMA Council on Medical Service, C. Rufus Rorem, M.D., of the Philadelphia Hospital Council, Louis Wright, M.D., New York, and Messrs. Horace R. Hansen of the National Co-operative Health Federation and Harry Read of the CIO.

* * *

MEDICAL CARE FOR THE INDIVIDUAL

Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare requested the Brookings Institution to make a survey for the use of his committee in considering National Health Legislation. The full report will be published at a later date but the conclusions are as follows:

Conclusions

The conclusions based on this foundation are:

1. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogenous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.

2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care.

3. The nonwhites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.

4. The advances in health among both the whites and the nonwhites have been made in the United States in the past four decades do not suggest basic defects in the American system.

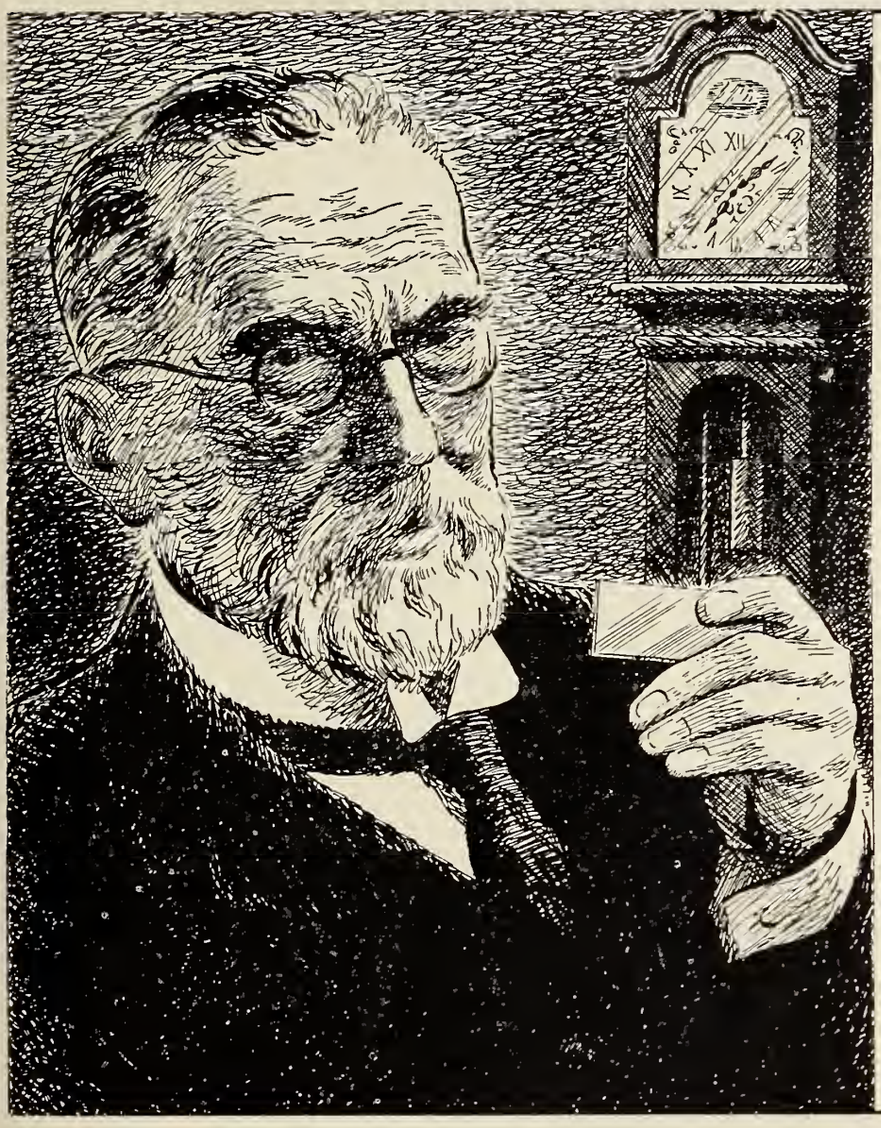
5. Although the statistics resulting from the administration of the Selective Service Act—the so-called draft statistics—have been widely used to show bad health among the American people and the need for revolutionary changes in arrangements for medical care of individuals, they are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole.

6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the Second World War.

7. The conditions in extremely poor rural areas that lack the resources to support adequate public services, such as health work, education, and highways cannot be satisfactorily solved by subsidies. This problem calls for a radically different approach, either bringing in new or

(Continued on Page 602)

Experience is the Best Teacher



Paul Ehrlich
(1854-1915)
proved it in chemotherapy

Paul Ehrlich, expanding on his knowledge gained as a pupil of Koch, concluded from his experiences in the staining of bacteria that there was a close chemical affinity between the cellular body and the stain. This idea led him to believe that specific drugs could be found which would kill invading pathologic organisms, without damage to the host. His conclusions helped create the science of chemotherapy, which is increasingly important today.

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Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

MEDICAL CARE FOR THE INDIVIDUAL

(Continued from Page 600)

improved economic activities or getting the people to more favorable and administratively less expensive areas. This condition has been accentuated by the emigration of youth from these areas to urban communities.

8. The United States has some individuals and families not possessed of the resources to enable them to pay for adeqquate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements.

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

12. The administration of compulsory insurance would require thousands of Government employes for accounting, auditing, and inspection and investigation.

13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency to insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.

14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.

15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (a) fee for service, (b) per capita, or (c) salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

Recommendations

1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent co-operation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Government administration. It seems highly improbable that this experimentation—possible under our Federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtless then be adopted with a great degree of unanimity. If compulsory insurance should be adopted now by a narrow vote in the Congress, thousands of persons who are opposed to it would start hostile to the whole undertaking.

2. For the time being the National Government and many of the State governments may well devote their resources and energies to:

(a) Research and developments in the fields of public health;

(b) Health education at the school level;

(c) Teaching of preventive medicine;

(d) Assisting in the acquisition of physical facilities and training of personnel;

(e) Providing systematic care for the indigent and the medically indigent. In some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and co-ordinated program.

3. From the standpoint of public relations, governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, State, and local voluntary organizations which have been able to enlist the active co-operation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are nonmedical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest, and co-operation of individuals, families, and local communities.

These recommendations are not widely at variance with those of the majority of the Committee on the Costs of Medical Care, arrived at in 1932 after a comprehensive study. The report of the committee says:

* * * [The] majority of the committee does not endorse the recommendation which would make health insurance a legal requirement for certain sections of the population. These members realize that such a step may ultimately be necessary and desirable in some States, but they believe that for most States and probably for almost all of them at the present time, it is much more desirable (a) to encourage voluntary measures for protection against wage loss during sickness, and (b) to develop voluntary insurance for medical care in conjunction with group practice, with hospital service, and with the related measures recommended on the preceding pages. They are of the opinion that the difficulties of these plans can be controlled by a combination of professional and community effort, and that these plans hold the promise of steady extension in scope of service and in proportion of the population served. These members believe that the various payment plans (aside from compulsory insurance) if fully carried out, would: (1) largely solve the problem of hospital costs which constitute about 50 per cent of the average family expenditure for the care of sickness; (2) provide adequately for many rural areas in which serious deficiencies of facilities exist at present; (3) make more nearly adequate provision that exists at present for the "indigent" and for the care of certain diseases of public importance; and (4) provide, through voluntary co-operative insurance * * * medical service to a majority of the 70,000,000 people living in industrial communities and in cities.[3]

[3]Medical Care for the American People, the final report of the Commitee on the Costs of Medical Care, Oct. 31, 1932, p. 130.

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Editorial Opinion

OFT IN THE STILLY NIGHT

The public, according to complaints received by the American Medical Association, believes that it is not getting the service it requires from its doctors. A particular grievance is the difficulty—on occasions the impossibility—of obtaining emergency medical service at night.

For various reasons a reactionary attitude toward self-sacrifice has set in since the war. The devotion to a common cause in those soul-trying years elevated many persons to a heroic state of mind. Now, at least in this country, "We the people" are demanding the pay-off. We want things material, and we want them now.

The medical profession must bear its share of this failure to see eye to eye and clearly. In too many phases of its work there has been an increasing divergence from the public interest rather than an improved cordialty in public relations. The trend toward socialization has been a trend also toward the impersonalization of medical service.

During the war, 60 per cent of the nation's physicians —and they comprised the older group—remained at home, assuming their absent colleagues' duties. They were, on the whole, overworked, but, on the whole, as old-timers they accepted the responsibilities that appeared to them to be part of the obligations of a career of service. Many of them now believe that others should bear the extra burden, and this is what the others seem unwilling to undertake. The youngsters seem to have failed to acquire the idea that they have accepted a calling.

If an obligation implicit in the practice of medicine now fails of spontaneous fulfillment, however, some organized measures must be taken to provide what is lacking. The American Medical Association suggests that county medical societies or urban groups maintain telephone exchanges that will accept the responsibility for locating physicians available for emergency calls.

The majority of the older practitioners have led lives so organized that they were never, year after year, "off call" without a substitute constantly available. It is one of the responsibilities that those who care for the sick have accepted and must continue to accept: Those for whom they care must never be abandoned.—Editorial, *The New England Journal of Medicine,* May 6, 1948.

THE JOB OF THE COUNTY MEDICAL SOCIETY

"The County Medical Society in many areas has become just another society." This statement by Dr. Louis Bauer, (AMA Trustee and President of the Medical Society of the State of New York) is an alarming truth. Medicine has become over-organized. Surgical societies, obstetrical societies, pediatric societies, general practice societies, and others have sprung up everywhere. In many places this movement has reduced the interest in county society activities, has lowered attendance at society meetings, and has diminished the influence of the county medical society in the community.

Today the influence of the county medical society is needed more than ever before. The individual physician must be kept united and informed; the public must be educated as to the problems of medicine, both scientific and economic; and liaison must be maintained with lay groups and organizations in the community. These are functions of the county medical society.

What are the responsibilities of a county medical society? The county medical society has a responsibility to the public, a responsibiilty to its membership, and a responsibility to medical organization. There is no order of preference; all are equally important. One cannot survive without the other two.

The first step toward understanding within the membership is to succeed in an understanding among the county medical society officers.

The Third National Conference of County Medical Society Officers, scheduled for June, is designed to assist in this step as well as to arrive at a measure of agreement in regard to the meaning and extent of such responsibilities. Every county medical society has been issued an invitation to send its officers to the Conference. Each officer attending will be free to enter into the discussion and to express his thoughts and ideas on THE JOB OF THE COUNTY MEDICAL SOCIETY.

The thoughts and ideas expressed will be correlated and forwarded to the president or secretary of each county society and from there on it will be up to them, and to every committee member, and to every society member, to give attention to the problem.

The county medical society is as effective or as ineffective as its success in carrying on its responsibilities. Such success depends on the individual physicians who make up each society.

THE STRENGTH OF A CHAIN IS THE STRENGTH OF ITS WEAKEST LINK. DON'T HAVE ANY WEAK LINKS IN YOUR SOCIETY.—Editorial, Kent County Medical Society *Bulletin,* May, 1948.

SHOULD BUREAUCRATS PRACTICE MEDICINE?

A good deal of what is happening in Britain under a labor government is of pressing interest to Americans, because some of the rough going encountered by social theorists looks like a preview of what can happen in this country under similar legislation.

To take one very important example, the Socialist majority in Parliament passed the National Health Service Act. Its provisions, to go into effect on July 5, 1948, were designated to unify medical and auxiliary services in an insurance scheme directed by the state and supported by compulsory contributions from all citizens. However, physicians were to be free to join or not to

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Should Bureaucrats Practice Medicine

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join the contemplated service, as they pleased. This preserved a principle of freedom, at least in appearance. The British Medical Association opposed passage of the law, but the Minister of Health and his advisers felt confident that they had written in enough guarantees of economic security to attract rank-and-file doctors.

In February, almost five months before the act will take effect, the BMA—comparable to the AMA in this country—took a plebiscite of all doctors on the register. The Minister of Health intimated that the plebiscite would be framed, and that the BMA was a fogbound organization of Tory reactionaries. Beatrice and Sidney Webb, the father and mother of the British Labor Party, once described the BMA as a most enlightened and responsible professional body. That made no difference. It was now in the way, and had to be smeared.

The result of the poll ended all talk of sinster pressure. Eighty-two out of every hundred physicians eligible to vote filled out their ballots and signed their names. Nearly 90 per cent said they disapproved of the plan, and would not join it.

For eager social engineers, the figures were baffling. No matter how they were broken down, examined and analyzed, it was plain that a nonpolitical group, many of whom must have voted Labor in the last general election, had returned an immense majority against the government. As The Economist pointed out: "Youth and crabbed age, serviceman and civilian, salaried and nonsalaried, public and private practitioner, specialist and general practitioner—all have decided, by a large majority, to put professional solidarity first."

In the practice of medicine, professional solidarity is not only economic in character, it is also at the root of ethical standards and of the doctor's freedom. If the BMA stands almost 9 to 1 against the scheme, they must have more than pocketbook reasons, in view of the attractive terms offered in the act.

One explanation of their stubborn resistance to Utopia might be found in the notorious waste of medical and surgical skills by the armed services, abroad as well as here, during the war. In a rigid framework of state authority, whether political or military, earnest and able doctors frequently find themselves blocked off in idle corners or working under superiors in rank only.

Moreover, the old adage about paying the piper and calling the tune still holds. In this country, for example, a specialist treating a tuberculous veteran receives his fee from the Veterans Administration. But he may not use streptomycin in the treatment, except in the amounts and at the intervals and under the conditions prescribed by the VA. Some very eminent experts disagree completely with the official method, and describe its enforcement as little more than using veterans as guinea pigs. That makes no difference when Authority has spoken.

Points like these, which are really capital points, not only from the physician's point of view but from the patient's, are brushed aside by British and American planners. After the plebiscite of the BMA, the Minister of Health talked darkly of "sabotaging an act of Parliament"—surely a strange expression to use about professional men who announced a choice which the law explicitly allows them.

In the United States, advocates of the National Health Insurance and Public Health Bill, commonly called the Wagner-Murray-Dingell Bill, take the same high line. They describe the Taft Bill as only a "sop," because it limits Federal assistance to places where it is needed and to persons who have no other resources. The AMA opposes the grand design of national health insurance, with its 3 per cent payroll deductions, its cumbersome controls and all the rest of the familiar features of bureaucratic legislation. The doctors, with the exception of a small independent committee, have endorsed the Taft Bill.

Before this country gets into anything like the British medical stalemate, it might be a good idea to consider whether the large majority of people practicing a profession are not the best judges of how to extend and improve their service.—Editorial by Paul Jones, *Saturday Evening Post,* May 1, 1948.

INTERPRETATION

Hospital residents have been ruled educational trainees by the administration. This makes veteran residents in civilian hospitals eligible for increased subsistence allowances under the recently-passed Public Law 411. Interns are classed as on-the-job trainees, and still are not eligible for the raise.—*Hospitals,* May, 1948.

MEDICAL CARE FOR THE INDIVIDUAL

(Continued from Page 602)

The years since 1932 have witnessed—

1. A great growth in voluntary insurance both for hospitalization and for medical services.

2. State experimentation with compulsory health insurance in Rhode Island and California.

3. A growing willingness on the part of practitioners to co-operate in the development of prepayment plans and other devices to enable patients who so desire to regularize their payments for medical care.

4. A profound change in the amount and distribution of the earnings of the American people. This change greatly reduces the number who cannot afford adequate medical care if they desire to purchase it.

The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the majority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress.

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The Cornelian Corner

Practical Application of Basic Mental Hygiene Principles

By Leo H. Bartemeier, M.D.

Detroit, Michigan

SOME TIME during the early months of 1942, two Detroit physicians, a pediatrician and a psychiatrist, who regularly met each other for luncheon, began to engage in serious discussions about a problem which had been concerning each of them for a rather long time. The pediatrician was preoccupied with the difficulties which so many mothers experienced in connection with the feeding and the care of their infants. It seemed to him that much of their anxiety and the obvious dissatisfactions of their infants were unnecessary and unnatural. In his effort to solve this problem he had broken with the traditional procedures and had advised the mothers to feed their infants as often as they seemed to want nourishment and to let them have as much as they would take. The results had been most gratifying. The mothers' anxieties diminished and the infants were appreciably more contented. This departure from the rigidity of feeding schedules was contrary, however, to what he had been taught and not in keeping with the practice of his colleagues. The psychiatrist with whom he discussed this matter had been particularly concerned about the difficulties he had experienced in treating patients who suffered from severe mental disorders which often required long periods of hospitalization. He knew that their illnesses stemmed from intense dissatisfactions they had repeatedly suffered in their infancy and babyhood. He was intrigued with the contentment and satisfaction of both mothers and infants which the pediatrician had observed after he had allowed the infants to indicate how much and how often they should receive nourishment. In this radical break with traditional pediatric procedure, the psychiatrist saw one possibility for improving the mother-child relationship and for lessening the incidence of the serious mental disorders of adult life. Like the pediatrician he was especially interested in preventive medicine.

These two physicians then began discussing their mutual interests with a few of their colleagues, and they learned that they too were concerned with the same problems. This small group, which included an obstetrician, an expert on nutrition, a registered nurse and a clinical psychologist, decided to continue and enlarge the original discussions between the psychiatrist and the pediatrician and to meet at regular intervals for the purpose of this collaboration. Accordingly, on November 12, 1942, they formed a small organization which they named the Cornelian Corner. The first article of the constitution which they framed at that time describes why they chose this name for their society. It reads as follows:

"This association shall be named after Cornelia, daughter of Scipio Africanus, the Elder, mother of the Gracchi and of Sempronia, the wife of Scipio Africanus, the Younger. On the death of her husband, refusing numerous offers of marriage, she devoted herself to the education of her twelve children. When asked to show her jewels, she presented her sons, and on her death a statue was erected to her memory inscribed, 'Cornelia, the mother of the Gracchi.' The sons, Tiberius and Gaius, devoted their lives to the welfare of their fellow men.

"When the kitchen was used by the family as a 'living room' it was customary for the mother to face a corner of the room when nursing her infant. Thus her back was turned to others in the room, and both she and the infant were more removed from disturbing influences."

During the early meetings of this small group their discussions were confined in the main to the cultural influences which have effected a near disappearance of the nursing of infants, and how this natural procedure might be re-established in the American scene. As their discussions continued, their objectives came to include all those early parental influences which determine so importantly the favorable or unfavorable evolution and development of character traits. They outlined these objectives in Article II of their constitution, which reads as follows:

"*Purpose*—Believing that a program aimed at relief of the cultural tensions so frequently incident to feeding, toilet training, and child discipline, represents the nuclear approach to the problem of mental hygiene, we dedicate ourselves to such a program.

"The purpose of this association, therefore, shall be to promote healthy parent-child relationships.

"We will strive toward the achievement of this objective:

1. Through research in the fields of child development and family life.
2. Through the education of parents, especially expectant mothers and fathers, as to the basic needs of the developing child.
3. Through the wide promulgation to professional groups of all pertinent information regarding the developing child and his environmental needs.

(a) We will strongly advocate the abandonment of the artificial practice of separating the newborn child from his parents.

(b) With the conviction that it is advantageous to both mother and child, we will encourage the breast feeding of infants with opportunity to nurse whenever the infant is hungry or anxious."

During the five years that it has been in existence, the Cornelian Corner has won the interest and the enthusiastic support of a surprisingly large number of people. For the past two years it has conducted seminars for physicians and for the nurses in charge of the pediatric and obstetrical wards in the general hospitals of metropolitan Detroit and the neighboring communities. These seminars have been made possible through a grant from the Children's Fund of Michigan. They have been conducted by leading pediatricians, psychiatrists, obstetricians and other specialists in the field of child development. In addition to this educational project, the Cornelian Corner has gained the co-operation of five Detroit hospitals in its project to have infants remain in the same room with their mothers from the time of their birth. This has already been carried out in a number of instances, and some valuable data have been collected which already demonstrate the desirability for such procedures.

This brief history of the Cornelian Corner of Detroit constitutes a new development in preventive medicine and represents the first organized reaction to the most crucial human problem in our culture. This problem is reflected in the objectives of the Cornelian Corner. These objectives aim to re-establish the practices in infant care which were in vogue fifty years ago, when babies were born in the home and mothers and fathers sensed the importance of satisfying their needs. Fifty years ago it was customary for mothers to nurse their babies, to feed them as often as they seemed to need nourishment, and to give them a great deal of mothering. Fathers commonly assisted in the care of their infants, and brothers and sisters had free access to the new baby almost from the time of its birth. These practices were wholesome and natural, but many mothers died in connection with childbirth, and the percentage of infants who succumbed to infections was very large. It is a tribute to the progress of medical science that the number of maternal and infant deaths has been reduced to a minimum. The scientific discoveries which have protected the lives of so many mothers and infants have eliminated; however, many of the old-fashioned practices connected with infant care. Physicians have concerned themselves with the strict enforcement of all procedures which insured the saving of human life. The personal care that mothers and fathers had previously bestowed on their newborn became the professional duty of hospital nurses, and the isolation of the infant became an accepted procedure. Strict medical rules and regulations for the feeding and general care of the baby in the home replaced the natural ways in which parents of a former generation looked after their offspring.

The Cornelian Corner encourages the restoration of these folkways within the framework of present-day medical procedures. The rationale for this new effort lies in the fact that the great discoveries of Freud have revealed that the old-fashioned practices were psychologically sound and essential for the wholesome evolution and development of personality. These discoveries, which were derived from years of painstaking clinical investigations, have not only been confirmed by the researches of many other psychoanalysts but

have gained general acceptance by psychiatrists and an increasing number of pediatricians. These discoveries reveal why the separation of infants from their mothers and fathers in our modern hospitals is unhealthy for both the parents and their offspring, and why it prepares for difficulties in the subsequent parent-child relationship. These clinical investigations have repeatedly demonstrated that throughout the period of infancy and babyhood the entire existence of every child is dominated by two inherited strivings. One of these is the instinct of hunger, and the other is the instinct for love and all that it implies at this period of development. Experiences which interfere with the gratification of either one of these instinctual strivings produce tension, discomfort and pain. The repeated occurrence of such states of tension gives rise to anxiety, to disturbances in digestion and to other interferences with the natural development of the child. Every infant, for example, in addition to the satisfaction of his hunger, also needs the gratification of his impulse to suck. No man-made schedules can adequately supply the satisfactions of these instinctual needs. They are inherited biological strivings which every good mother senses and knows how to satisfy. They vary in their intensity from one child to another—just as each infant even in the same family shows individual characteristics from the time of its birth. The need for a great deal of close proximity to his mother's body and all that we understand by the term mothering is just as important for the wholesome development of the infant as the need to be adequately fed. This natural mothering establishes the first human relationship which becomes the foundation for all other subsequent relationships and influences the character of the individual throughout his entire life. These facts demonstrate the necessity for the natural mothering process from the time of birth and throughout the period of infancy and babyhood. In brief, we now possess a body of scientific knowledge regarding the optimum care of the child which demonstrates that the parents of a former time sensed the instinctual needs of their infants and the necessity to satisfy them for the sake of their well-being.

The second objective of the Cornelian Corner is "the education of parents, especially expectant mothers and fathers, as to the basic needs of the developing child." The Cornelian Corner encour-

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Allergic Dermatoses

Recognition and Management

By Sidney Friedlaender, M.D.
Detroit, Michigan



ALLERGIC REACTIONS involving the skin constitute a great percentage of the skin eruptions commonly encountered in daily practice. It is essential to recognize the allergic nature of these conditions in order that proper treatment may be carried out. The determination of specific sensitizing factors is the keystone in the successful management of allergic dermatoses. These specific elements may be fairly obvious in some cases, while a careful and diligent search may be necessary to uncover them in others. A thorough history is an extremely important aid in properly classifying allergic skin reactions, and in addition will often reveal important points of etiologic significance. Laboratory aids, such as cutaneous, intradermal, and patch tests, give valuable information if properly performed and intelligently interpreted.

Considerable morphologic difference exists in the various allergic syndromes of the skin, but all have in common a specific sensitization mechanism. The most frequently encountered dermatoses in which allergy is agreed to play a dominant role are atopic dermatitis, contact dermatitis, urticarial eruptions, "id" reactions, and drug eruptions. While the lesions in these syndromes are not always typical, they assume for the most part a characteristic configuration and distribution, which aid in their classification and diagnosis. The important points in the recognition, etiology and management of these conditions will be considered in the ensuing discussion.

Atopic Dermatitis

This widely encountered allergic skin disease is frequently designated in the literature under such terms as eczema and flexural eczema. Some cases referred to as disseminated neurodermatitis and lichen simplex chronicus disseminatus may also belong in this group. Atopic dermatitis can occur

in infancy, chilhood or adult life. Cases which begin early may disappear before the age of puberty, while others frequently continue into adulthood. Ofttimes the dermatitis begins in late childhood or young adult life without a preceding history of the infantile type. An initial onset of the disease in older adults is not rare. For purposes of discussion, however, it may be well to consider the earlier type, infantile eczema, apart from the atopic dermatitis of childhood and adult life. All are essentially the same disease, the disturbance involving the superficial layers of the cutis. The allergen responsible, usually protein in nature, is absorbed from the respiratory or gastrointestinal mucosa and reaches the superficial blood vessels of the cutis by the hematogenous or lymphogenous route. Immediate whealing reactions to specific allergens are obtained on cutaneous or intradermal testing in this group of patients. The proper interpretation of these reactions is of great value in planning specific therapy.

Infantile eczema usually begins in the first two or three months of life, involving the face and later spreading to the extremities and trunk. It is associated with considerable pruritis, and the resultant scratching frequently results in a secondary infection. The lesions are pleomorphic, often characterized by vesicle formation, oozing and crusting. As the disease progresses, a flexural distribution becomes more evident. In some cases the eruption disappears spontaneously by the end of the second year, only to be replaced by other allergic manifestations such as rhinitis or asthma. In other cases the disease may continue and assume the characteristics of the atopic dermatitis of older children and adults. A high incidence of familial allergy is present in these infants, attesting to the atopic nature of the condition. As already mentioned, the skin disorder is frequently the first of a series of allergic manifestations scheduled to occur in that individual. Control of the cutaneous allergy early in life may go far in influencing the course of later and more serious disturbances of the respiratory tract.

Food is the most commonly recognized cause of atopic dermatitis of infancy, either reaching the child through the mother's milk, or by direct ingestion in the case of the artificially fed infant. Among the foods often causing difficulty are cow's milk, wheat, eggs, citrus fruits, fish oils, and meats. In recent years it has become more widely recognized that environmental allergens play an extremely important role in these infants, and that measures for their control should be instituted early.

The atopic dermatitis of children and adults assumes a greater flexural distribution, although generalized involvement of the face, neck, trunk and extremities is frequently observed. Erythema, papulation, vesiculation, with later lichenification, is the characteristic picture in this group. Pruritis is a prominent feature and during exacerbations, the rupture of vesicles by scratching results in oozing, crusting, and secondarily infected lesions. In children a spontaneous involution may occur around the age of puberty. In others the disease extends into adult life. The condition is by no means limited to young adults, and is observed in individuals past forty. In some instances it may even orginiate after the age of fifty without any preceding history of eczema or other allergic disease.

Associated allergies of the respiratory tract are commonly present in these patients, and often intense enough to relegate the cutaneous allergy to a secondary place in the over-all allergic management. Food allergens, while important in many instances, play a less significant role than in the infantile type. Inhalants, such as house dust, pollen, molds, feathers and animal danders, assume a greater importance in these cases. Sensitivity is frequently extreme, and the small amounts of antigen used for hyposensitization may be sufficient to flare up the skin lesions.

While specific sensitization is the prime etiologic element in atopic dermatitis, nonallergic factors may also have some influence. Emotional stimuli, endocrine imbalance, and atmospheric changes are among the non-specific factors that may exert some effect in these individuals. Not infrequently, observers are prone to attribute primary etiologic importance to these nonspecific factors, because of their association with exacerbation of skin lesions. These influences play no more than a secondary role, and frequently are the trigger mechanisms which upset the allergic balance and initiate symptoms.

Contact Dermatitis

This type of allergic response, which includes the industrial dermatoses, constitutes a large proportion of all dermatologic lesions. It is essentially a disease of the superficial skin layers resulting from direct contact of the allergen with the epi-

dermis. Lipoids, oil soluble substances, metals, simple chemicals, and dyes are frequently the cause, in contrast to the protein allergens which are the offenders in many other types of allergic reactions. The dermatitis in these cases is dependent to some extent on the potency of the sensitizing agent, the length of exposure, and the resistance of the skin. Thus, industrial workers may develop a contact dermatitis from a potent sensitizer after relatively short exposure, while a less active agent may require a longer period to produce an eruption. Skin whose resistance has been lowered by contact with strong acids or alkalis, or by the presence of other skin disease, may be more readily sensitized than skin whose normal protective barriers are intact. In any case, the skin must be initially sensitized before subsequent exposure will result in an eczematous response.

The primary lesion of contact dermatitis is the vesicle, which may appear from several hours to several days after exposure to the contactant. Initially the lesions are localized to the area of contact, but may later become generalized. Frequently they are limited to the exposed parts of the skin not covered by protective clothing. In other instances the eyelids or neck may first be involved, despite earlier contact with other parts of the skin.

The most notable example of contact dermatitis is that produced by poison ivy and related plants. The lipoid antigen of poison ivy is capable of readily sensitizing the majority of individuals. The oily fraction of the ragweed group of plants are also frequent sensitizers during the summer months. Various materials in industry are responsible for cases of contact dermatitis. Among the most common are dyes, coal tar products, paints, lacquers, solvents, resins and waxes. The dyes and finishes in various articles of clothing are frequently incriminated in nonindustrial cases. Cosmetics constitute a great source of difficulty in women. The frequency of nail polish dermatitis is now commonly recognized, and eruptions from soaps, lipstick, hair lacquer, leg make-up, deodorants, and hair dyes are frequently seen. Metals such as nickel, mercury, chrome and their salts, which are almost universally encountered, are frequently responsible for dermatitis. The use of local anesthetics, mercurials, sulfonamides, penicillin, and many other common drugs in the form of ointments or solutions used for skin therapy will frequently produce a contact dermatitis superimposed on the primary skin condition under treatment.

Specific diagnosis of contact dermatitis is carried out by means of the patch test. The primary irritant properties of the test substance must first be ascertained in order that a proper interpretation may be made. It must be prepared in a form which will not produce an irritating reaction in a nonsensitive individual on prolonged contact. The test materials are applied to the skin and covered by a patch, a reading being made at the end of twenty-four to forty-eight hours. Any resultant positive reaction is a duplication of the contact lesion.

Urticaria and Angioneurotic Edema

These two conditions are essentially the same disease, modified by the structures they involve. The primary lesions is the wheal, which is considered by many to be the basic unit of the allergic reaction. Urticaria signifies the small discrete lesions involving the superficial layers of the cutis accompanied by intense itching, while angioneurotic edema consists of localized edematous swellings involving the subcutaneous tissues and other deeper structures. These larger swellings are prone to occur in the tissues of the lips, eyelids, tongue, hands and feet while the smaller urticarial lesions more frequently occur on the trunk, arms, and thighs. Cutaneous and intradermal testing may give important information in this group of cases. While the clinical correlation between positive skin reactions and symptoms is not as frequent in this group as in other forms of allergy, the tests occasionally give important diagnostic information which justifies their performance in difficult cases.

Considerable difference of opinion exists regarding the etiology of urticaria. While it is difficult to prove conclusively an allergic basis in each case, this type of approach offers the best possibility of an ultimate solution of the more vexing cases. A fair percentage of patients with urticaria give a familial history of allergy, and in many instances have other syndromes of an atopic nature. Gastrointestinal dysfunction, focal infection, endocrine imbalance, and psychic factors have been accused of primary importance in chronic cases. These undoubtedly play a part in certain instances, but it seems more likely that they are not the primary cause, but act as secondary or aggravating factors.

Acute and chronic types of urticarial eruptions

are recognized. Fresh fruits and vegetables, seafood, and nuts are often etiologic factors in acute cases. Staple foods such as wheat, milk, egg, corn, and white potato are more likely to be responsible for chronic cases. Drugs very often produce severe urticaria. Aspirin, barbiturates, and penicillin are among the most frequent offenders. The wide use of penicillin recently has resulted in an increasing number of severe "serum sickness type" of urticarial reactions which may persist for many days after the medication has been discontinued. Injectable substances, such as liver, insulin, and therapeutic serums, may also cause urticarial reactions. Environmental allergens, such as pollen, animal danders, cottonseed and flaxseed, may produce urticaria in sensitive individual upon inhalation. Urticaria from physical agents, such as heat, light, and cold is not uncommon.

"Id" Reactions

"Id" reactions represent an acute allergic response of an inflammatory nature to the metabolic products of fungi. Localized fungus infections of the skin are capable of sensitizing the entire skin to their products of growth. This sensitization is similar in nature to that produced in tuberculosis, and is demonstrated by the delayed inflammatory reaction elicited by the intradermal injection of the fungus extract in sensitive individuals.

The allergic responses which frequently occur spontaneously in those suffering from fungus infections of the skin are termed trichophytids, epidermophytids, monilids, or microsporids, depending on the causative infecting agents. Fungi cannot be recovered from these lesions, since they do not represent a spread of the infection. The feet are the most common site of primary fungus infections, while the hands are most frequently the site of the "id" reaction. The secondary lesions on the hands are usually vesicular in nature, occurring singly or in groups, and are accompanied by intense pruritis, often breaking down to form a fissured and eczematized dermatitis. "Id" reactions are not always limited to the hands, and may at times be generalized and papular or lichenoid in nature. They may often be confused with other dermatologic conditions, and diagnosis should be based on the appearance of the lesions cofection elsewhere. Inasmuch as primary fungus existant with the presence of an active fungus ininfections of the skin are so prevalent, the "tuberculin-type" reaction obtained from fungus extracts may be obtained in the majority of individuals and be of little help in making the diagnosis of "id" reaction. A negative response would be of more significance in ruling out these lesions. Occasionally an immediate whealing reaction is obtained on testing with fungi, and may be of greater significance in diagnosis than the delayed type.

Drug Eruptions

Skin eruptions following the use of drugs (dermatitis medicamentosa) are commonly encountered and must always be considered in the presence of a dermatitis of doubtful etiology. Such common drugs as aspirin, antipyrine, bromides, iodides, opiates, mercurials, arsenicals, quinine, phenophthalein barbiturates, sulfonamides and penicillin, may produce dermatoses. Despite clinical evidence of sensitization, as demonstrated by the recurrence of the eruption following the use of the drug, skin tests with drugs are usually negative. There is considerable experimental evidence however that drugs, which are compounds of low molecular weight as compared to protein antigens, combine with body protein to form an antigenic complex responsible for sensitization.

Urticaria is the most common form of skin eruption following the use of drugs, and has already been discussed. Morbilliform rashes, acneiform lesions, purpura, bullae, fixed eruptions, erythema nodosum and multiforme type lesions are frequently the result of drug sensitivity.

Treatment

The most satisfactory results in the management of allergic dermatoses are obtained by a judicious combination of specific and nonspecific treatment. Local dermatologic therapy and other nonspecific measures designed to control inflammation, pruritis, and secondary infection, are helpful in restoring the skin to its normal state. A great deal cannot be expected from such treatment in most cases, unless the specific allergens responsible are determined and controlled.

Nonspecific Treatment.—Local therapy employed in the acute phases of allergic dermatoses is in no way different from that used in other types of acute dermatitis. Wet dressings of Burow's solution, boric acid, or potassium permanganate are helpful in controlling the acute inflammatory

reaction of the skin. In the subacute and chronic phases, lotions and ointments may be employed. Such therapy must always be used with care because of the possibility of aggravating the skin condition. In the subacute phase, lotions such as calamine with or without phenol may be helpful. Bland ointments containing boric acid or liquor aluminum acetate in aquaphor or lanolin are frequently desirable. In the more chronic stages, tar in the form of liquor carbonis detergens, or crude coal tar, combined at times with a small percentage of salicylic acid, may be applied in ointment form. The antihistaminic agents used orally, parenterally, or topically, are at times helpful in diminishing pruritus. In the urticarial dermatoses they are frequently successful in controlling the lesions. Fifty to 100 mg. four times daily is usually sufficient to keep the patient comfortable. In extreme cases 10 to 50 mg. of benadryl intravenously may be helpful in producing sedation and controlling symptoms otherwise resistant to symptomatic measures.

In the treatment of "id" reactions, it is essential to locate and control the primary focus of infection. Treatment of the infected area with fungicidal agents will frequently result in the disappearance of the secondary "id."

Specific Therapy.—The treatment of specific allergic factors is of course dependent on their recognition. While skin tests are helpful in making an etiologic diagnosis, too much dependence is often placed on this laboratory procedure. Without a careful history, physical examination, and an understanding of the applicability and limitations of skin tests in the case under study, they frequently are of little help, and in many instances totally misleading. Properly employed and interpreted, they are an extremely valuable aid in diagnosis. Specific therapy in the allergic dermatoses is based on the elimination of the offending allergen wherever possible. When this cannot be accomplished, desensitization is indicated. The control of specific allergens can be conveniently discussed under the headings of ingestants, inhalants, and contactants.

Ingestants.—Where food or drugs are the cause of allergic symptoms, the most satisfactory treatment is obtained by complete elimination. The determination of the offending ingestant entails study beyond history taking and skin testing. Trial diets and the use of the food diary are frequently necessary to confirm the diagnosis. Rarely it may be necessary to consider desensitization. This may be attempted in the case of such basic foods as wheat, milk, or eggs. In such instances, the oral route is employed. Doses of the specific food below the symptom-producing level are given orally in gradually increasing amounts until the patient is able to tolerate the food normally. Adequate desensitization by this procedure may be difficult, and is often impossible to attain. Hypodermic desensitization to foods is not satisfactory, and frequently is dangerous.

Various approaches may be used in dietary investigation. A preliminary diet, based on the elimination of positive skin reacting foods, is frequently tried. The Rowe type diets, employing a relatively small number of foods of low antigenicity, are often used as a starting point. The elimination of certain foods from the diet on basis of their frequent association with the type of condition at hand may be adaptable to some cases. The use of a single basic food for a period of time, to which additions are gradually made, is sometimes applicable, but in most instances is very difficult for the patient to follow. Some time ago we experimented with the use of synthetic diets containing amigen, dextrose, mineral salts and vitamins as a starting point in the diagnosis of food allergy. The unpalatability of the mixture limited the use of this otherwise ideal approach. A week to ten-day period is necessary before the effect of a basic diet may be assessed. If symptoms have abated by that time, additions of single foods may be made at four- to five-day intervals, and flareups noted in relation to their introduction. A food diary is essential for a proper record, and may be helpful in determining any delayed reactions which can occur several days after the food has been introduced.

Inhalants.—History will often give a clue to the role of inhalants in skin allergy. The incidence of the eruption at certain seasons of the year, its aggravation in certain environments, and its improvements in relationship to change of climate or occupation, may frequently be noted. The correlation between positive cutaneous and intradermal skin reactions and clinical symptoms is often greater with inhalants than in the case of ingestants. Where a pet, an item of furniture, an article of clothing, or a cosmetic, is responsible for symptoms, the procedure of choice is to eliminate the offender

from the patient's environment. Inhalants such as dust, pollens and fungi, however, cannot be controlled by such simple measures, and it is necessary to employ desensitization when they are the responsible allergens. The method employed is similar to that instituted in other allergies such as rhinitis, asthma, and hay fever. It is usually necessary, however, to begin with much smaller doses of the specific antigen than used in respiratory allergies, because of the extreme sensitivity present in these patients. Exacerbations of skin lesions are prone to occur following injections, unless the patient's tolerance is correctly gauged.

Contactants.—The only completely satisfactory treatment of contact dermatitis is the elimination of the offending allergen. Desensitization therapy to most of the agents producing contact dermatitis, with the exception of the plant oils, is of little avail. Satisfactory desensitization is frequently possible in the case of the lipoid fractions of the poison ivy group and ragweed family. As previously mentioned in the discussion of contact dermatitis, patch testing is the investigative tool employed in specific diagnosis. The selection of materials for testing is dependent on the patient's environmental contacts. Care must be taken in their selection and preparation for testing. The use of skin as close as possible to the area of dermatitis should be employed. Positive reactions and their relationship to the dermatitis must be carefully evaluated. A positive test reaction to a certain substance does not necessarily incriminate that item as the cause of the current difficulty, since the skin may become sensitized to many substances after initial contact. Frequently it is necessary to differentiate a contact dermatitis from some other form of eruption. Testing with a group of common contact allergens may be helpful in classifying the condition. The occurrence of one or more positive reactors may indicate that the case is one of contact allergy, and further investigation of likely contactants indicated.

Summary

The allergic factors involved in such dermatoses as infantile eczema, atopic dermatitis, contact dermatitis, "id" reactions, drug eruptions, urticaria and angioneurotic edema are discussed. The recognition and management of these eruptions are reviewed in relation to the underlying specific sensitization mechanisms which play a part in their etiology.

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Dermatitis from Wearing Apparel

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WHEN WE compare the occurence of dermatitis caused by wearing apparel with the hundreds of millions of people exposed, the percentage is insignificant, but occasionally comparatively large outbreaks have occurred, when materials processed with new chemicals of unknown toxicologic properties were placed on the market. By far the large majority of cases of dermatitis from wearing apparel occur as a result of allergy. Dermatitis has been reported from wearing apparel made of silk, wool, synthetic fabrics, leather, artificial leather, furs, rubber, and synthetic rubber. Articles of wearing apparel reported as causing dermatitis were dresses, coats, trousers, stockings, socks, pajamas, brassieres, dress shields, rubber gloves, and rubber girdles. Metals and alloys used in jewelry which is worn next to the skin, such as rings, earrings, wrist watches, and eye glass frames have also caused dermatitis. Plastics used in spectacle frames, wrist watch straps, garters, and suspenders have also been reported as causing dermatitis.

Dermatitis from Fabrics

Occasional cases of dermatitis have been reported as due to allergy to unprocessed natural silk and wool, but the majority of reported cases have been caused by processed fabrics.

Fabrics in wearing apparel consist of the basic fabric and all the chemicals remaining in it from the processing operations. The principal chemicals remaining in the fabric are the dyes, mordants, and finishes.

Urbach[5] describes a case of allergic contact dermatitis from unprocessed silk. Most of the other authors reporting cases of allergy to silk have not clearly stated whether the silk was or was not processed, except Schwartz and Peck.[4]

Allergic dermatitis has been reported from wool and camels hair.[4] No cases of dermatitis have been

reported from unprocessed cotton and linen, although dermatitis occurs among flax pickers and from cottonseed oil.

Fabrics are also made of synthetic resins, glass, and casein. Regenerated cellulose, cellulose acetate, polymers of hexamethylenediamine adipate, vinyl chloride, vinyl acetate, and styrene are all used as synthetic fabrics. While dermatitis has been reported among the wearers of synthetic fabrics, they all occurred from the finished product and not from the unprocessed material.

Fabrics made of glass are now being used for linings, and cases of dermatitis reported from them have been due mostly to the mechanical irritation of the sharp glass fibers.[3] Spun glass is also used for stuffing pillows and mattresses to make them nonallergenic. Some industrial dermatitis occurs among glass fiber makers from the resins used to make glass thread and wool.[3] Dermatitis reported from synthetic resin fabrics have been due either to the plasticisers, stabilizers, dyes, mordants, and finishes.[4]

Dermatitis from the dyes and mordants on fabrics has been heretofore comparatively infrequent. Recently, cases have occurred more frequently, and the dyes used on synthetic fibers have been the cause. Certain of the azo dyes used to dye nylon have been at fault. These dyes have the property of swelling and coating and entering the nylon fibers, and if they "bleed" out they can cause allergic dermatitis. Dyes which "bleed" are the ones which most often cause dermatitis. Perspiration may dissolve them out of the fabric. Faulty dyeing which fails to remove excess dyes, mordants, and oxidizing agents from the fabric predispose to dermatitis. The special dyes used on synthetic fibers have powers to swell and penetrate the fibers. It is possible that this property is what makes them penetrate, swell and irritate the skin.

Plasticisers and stabilizers used in synthetic plastic films and threads sometimes cause allergic dermatitis. In cases of dermatitis caused by vinyl resins (Elastiglass), both plasticisers and stabilizers were at fault. In an outbreak of dermatitis from rubber hydrochloride (Pliofilm), the stabilizer was found to be the cause.

The finishes on fabrics are the most frequent causes of dermatitis. Finishes are applied to fabrics to make them look better, feel better, give better wearing qualities, prevent "runs," prevent wrinkling, hold the crease, make them waterproof, flameproof, mothproof, moldproof, insectproof, and antiseptic. Some finishes are removed by laundering and must be reapplied. Such are the finishes of phenyl mercuric acetate which are being applied to diapers with the mistaken idea that they will prevent diaper rash. They may cause dermatitis. Some finishes, because they are not readily soluble in water, stay more or less permanently on the fabric.

Finishes of starch have not been reported to cause dermatitis. Improperly neutralized sulfonated castor oil finishes have caused dermatitis.[1]

Antiwrinkle, crease-holding and "run"-preventing finishes usually consist of emulsions or solutions of synthetic resins and are applied to the fabrics in the dye bath. The resins are not completely cured when first applied, the cure being completed either in the heat of the dye bath or by heating after dyeing. Completely cured water-insoluble resins rarely cause dermatitis, but if the cure is not completed, the uncured resins remaining on the fabric may cause dermatitis. Dermatitis has been reported from incompletely "cured" ester-gums, phenol-formaldehyde and urea-formaldehyde resin finishes, but any of the uncured resin finishes may cause dermatitis.

Waterproof Finishes.—The insoluble metallic soap finishes used as waterproofing agents have not been reported to cause dermatitis. But dermatitis has been reported from waterproof finishes consisting of Japan wax (derived from rhus vernicifera). Tar and the resins used to waterproof fabrics used for outdoor shelters have caused dermatitis only among workers processing them. The new silicone resins are now being used for water-repellent finishes.

Flameproofing Finishes.—Fabrics are treated with chloronaphthalenes, ammonium sulfamate, borates, or phosphates in order to make them flameproof. The chloronaphthalene finishes may cause chloracne, and the ammonium sulfamate may cause dermatitis.

Mothproofing Finishes.—Silico fluorides, naphthalene, chlorbenzene, and chlorphenols used as mothproofing may cause dermatitis, but such cases have not been reported.

Delousing Agents.—DDT (dichlor-diphenyl trichlorethane), pyrethrum, rotenone, lethane, and

the thiocyanates are the principal delousing agents, and they may all cause dermatitis.

Antimold Finishes.—Most of the commercial mildewproofing agents are primary skin irritants and sensitizers. Some of them have caused dermatitis even when used in extremely low concentrations. The phenyl mercuric salts, dihydroxy dichlorodiphenyl methane, tetra brom orthocresol, paranitrophenol, and the chlorphenols are examples of antimold fabric finishes which have caused dermatitis.

Leather

The incidence of dermatitis caused by wearing apparel made of leather is small. Dermatitis has been most frequently reported from shoes. Shoe polish has often been blamed, but it is difficult to conceive how the polish can go through the leather, through the adhesive, through the shoe backing, and through the stockings to contact the skin. The inner linings and backings of shoes are made to adhere to the leather by means of adhesives similar to that used on adhesive plaster. The inner linings, stocking guards, inner soles and tongues of shoes are often impregnated with antimildews and fungicides with the mistaken purpose of preventing "athletes foot." In the experience of the author, the fungicides have been the chief causes of dermatitis from shoes. If the shoe backing is made of dyed leather, then the dye may cause dermatitis.

The tanning agents such as chromates and the dyes used on the outside leather are possible skin irritants, but it is only under rare circumstances that they can penetrate through the backing, lining, and stockings to contact the skin. Suspected cases of dermatitis from shoes must be differentiated from dermatitis from the stockings and from tinea pedis, and must be confirmed by patch tests with the inner parts of the shoes as well as with the stockings that were worn at the time that the dermatitis developed. If the stockings are at fault, then patch tests with the part of the stocking that is above the shoe tops should be positive. If only the part of the stocking inside the shoe, and touching the inflamed area, gives a positive patch test, it must be suspected that the irritant has been absorbed by the stocking from the shoe. Patch tests should be performed with that part of the inner lining of the shoe which corresponds to the inflamed areas on the foot. These should be positive. In the rare cases where the dye or tanning agents used on the outside leather are at fault, the inner lining is discolored by the dye. In cases of tinea pedis, the vesicles located under the instep, the cracks and scaling between the toes, the positive cultures obtained from the blister fluid or cracks, and negative patch tests to the shoe linings complete the diagnosis.

Dermatitis has been reported from leather wrist watch straps,[2] where a dye (amido azo toluene hydrochloride) was found to be the irritant.

The possible irritant chemicals in leather are any of the fungicides, the dyes, the tanning agents, and the oils and resins used to finish the leather.

Dermatitis from hat bands is not infrequent. Hat bands causing dermatitis have usually consisted of "artificial leather." This may consist of a fabric or paper base impregnated with a mixture of cellulose nitrate or acetate, oils, resins, and rubber. Scrap leather may be mixed with oil, rubber, and pastes, and pressed together into sheets to make artificial leather. The possible irritants in artificial leather are the dyes, resins, antioxidants and accelerators.

Dermatitis has also been reported from leather gloves and pocketbooks.

Furs

The large majority of the cases of dermatitis from furs have been caused by paraphenylenediamine and the other oxidation dyes. A few cases may be due to the chrome mordants, the tanning agents used on the fleshy sides of the pelts, or the mechanical irritation of the skin caused by contact with coarse hair. In order to develop dermatitis from the dyes and mordants, the wearer must be sensitive to these chemicals before the fur is worn, in which case dermatitis develops a day or two after the fur is first worn, or must become sensitized by wearing the garment, in which case the dermatitis occurs a week or longer after the garment is worn. Poorly dyed furs, from which the perspiration leaches the dyes, are the usual causes of inducing sensitivity. Once a person is sensitized, even the wearing of a well-dyed fur may cause dermatitis.

Paraphenylenediamine is a white crystalline chemical soluble in water. It must be oxidized in order to become a dye. The first oxidation product is quinone diamine, an unstable compound which is the actual cause of the dermatitis. Further oxidation results in the formation of comparatively non-irritant chemicals.

In recent years, the incidence of dermatitis from

furs has greatly diminished because they dyers use weaker solutions of dyes for longer periods in order to permit better oxidation, and they are taking greater care to remove incompletely oxidized dye from the furs by better "drumming" and washing.

Feathers

Dermatitis from wearing feathers has not been reported, but mucous membrane allergy to feather pillows and bedding is not uncommon. A new fabric made of feathers will soon appear on the market, and we may expect some allergic manifestations from it.

Rubber

Rubber is extensively used in wearing apparel. Gloves, girdles, dress shields, elastic stockings, shoes, and boots are often made of rubber. Dermatitis has been reported from rubber gloves, girdles, and dress shields. Previous to the last war, natural rubber was used, but now only the synthetic rubbers are permitted to be used for these articles. Dermatitis has become more frequent from wearing rubber articles since the use of synthetic rubber began, because unlike natural rubber, the synthetic rubbers themselves contain sensitizing chemicals, and in addition, when processing them, the same accelerators, antioxidants, plasticisers, stabilizers, et cetera, are added which are the actual causes of allergic dermatitis from natural rubber. Dermatitis often occurs from gloves, dress shields, and girdles made of synthetic rubber. The girdles are made of both fabric-covered synthetic rubber threads, and of sheets of synthetic rubber. Phenyl beta naphthylamine, used both in making and processing synthetic rubber, is the most frequent actual cause of the dermatitis. The accelerators used to vulcanize the rubber, and the chemicals formed on the surface of the rubber by the action of the sulfur monochloride used in the "acid" or "vapor" cures, are also frequently the actual causes.

Jewelry

Most of the reported cases of dermatitis from jewelry have been attributed to nickel and chromium contained in alloys, but ornaments made of the synthetic resins may cause dermatitis. Earrings, necklaces, lockets, watches, and spectacle frames have been reported as causes of dermatitis. The fluxes used in soldering jewelry sometimes contain fluorides and zinc chloride which are skin irritants.

Diagnosis of Dermatitis from Wearing Apparel

Dermatitis caused by wearing apparel begins at the site of contact with the offending material, five days or more after the garment was first worn. This is the length of the period of incubation for the development of sensitivity. The dermatitis may appear before five days if the patient has been sensitized to the offending chemical in the garment by exposure from some other source previous to the time that the garment was first worn.

The eruption is usually sharply limited and confined to the areas of the skin which had been touched by the garment. In those exceptional cases where the eruption is more or less generalized, the garment may have touched all the affected parts or the eruption may be a toxic one, the result of absorption of the offending chemical through the skin to the body. In such cases, systemic symptoms such as elevation of body temperature may accompany the dermatitis. The eruption may be a simple erythema or it may be edematous, papular, and vesicular. A patch test, performed with a piece of the garment while the dermatitis is in the active stage, should be positive if the garment is the causative agent.

Patch tests should be performed by cutting away a piece of the material, about 1 inch square, applying it to an unaffected skin site of the patient, covering it with an insulating substance—such as non-waterproofed cellophane, 1.5 inches square—and fastening this to the skin with a piece of adhesive 3 inches square. A similar patch is also placed on a control subject. (Circular patches of the same diameter may be used.) Experience has taught the author that more positive reactions result from large patches than from small ones. The patches are removed after twenty-four hours and the reactions read. A positive patch test confirms the diagnosis. A positive patch test on the control as well shows that the material contains a primary irritant. A negative patch test on the control and positive one on the patient shows that the chemical in the material is a sensitizer.

To find the actual irritant chemical in the fabric, an attempt should be made to ascertain from the manufacturer the names and to obtain samples of the dyes and finishes used on the fabric so that the patient may be patch-tested separately with each of them. If the manufacturer refuses to sup-

ply the information and chemicals, the following procedure will roughly determine whether the dyes, finish, or fabric itself is at fault: Soak the fabric in warm, slightly acidified water for twenty-four hours. If the water becomes discolored, the dye bleeds and may be the actual irritant. Concentrate the solution by evaporation in vacuum to about one-tenth of its original volume; immerse a piece of surgical gauze 1 inch square in the concentrate and patch-test the patient with it. If the dye does not bleed and the water remains colorless, follow the same procedure. If the patch test with the dyed gauze is positive, the finish or dye is at fault. If the patch test with the undyed gauze is positive, then the water-soluble finish is at fault. If it is negative, then suspect a water-insoluble finish. If both patch tests are negative, then soak a piece of the fabric in ether for a few hours to extract the ether-soluble finish; pour off the ether into a large shallow dish or crystal and allow it to evaporate, and perform a patch test with the residue. If possible, obtain a piece of the unprocessed fabric and patch the patient with it in order to pick up the rare cases of sensitivity to the fabric itself.

Treatment

Once the diagnosis of dermatitis from wearing apparel is made, the treatment becomes simple. The offending garment should not be worn and only soothing medication applied. Unless complications (secondary infection, lichenification, et cetera) have already set in, all cases should soon get well.

There is no positive evidence that acquired sensitivity to a chemical will make the patient sensitive to other unrelated chemicals, and that as a result the dermatitis cannot be cured. If a case of dermatitis, said to be due to a certain article of wearing apparel, does not get well after the article is discarded and bland treatment is given, there is grave doubt cast on the diagnosis.

Prevention

Manufacturers should have all new synthetic fabrics or all new chemicals used for processing fabrics tested by the "prophetic" patch test,[4] before placing them on the market. This will prevent outbreaks of dermatitis such as have occasionally occurred. The isolated cases of dermatitis which occur from fabrics which are worn by millions without trouble cannot be prevented.

(References on Page 685)

A Cancer Cemetery

A Great Culture Medium

By Harold S. Hulbert, M.D.

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THE CREATION of a cancer cemetery, for the development and isolation of a natural anticancer biotic, is a new concept. Reference to it has not been found in the literature.

Molds, over the ages, have developed specific or limited appetites and the ability to survive at the expense of certain rather specific substances. An example is penicillin. A related example is *phage*. Throughout many generations of bacteriophage, an antityphoid phage may be fed dysentery bacilli in the laboratory until that particular strain of phage becomes able to dissolve B. dysenteriae and no longer lives on B. typhosus.

"Cancer has a life history." First, there is the anlage, often long dormant. Then budding occurs, then growth, and naturally (meaning if there is no surgical or radiation interference) great growth takes place at the expense of the host's body, which dies.

Then what happens? The host and its cancer, which also died, are buried. Here, we will assume that no embalming has been done. Buried, the body and the cancer are destroyed by worms. The cemetery worms die. Cemetery molds destroy the cemetery worms and complete the destruction of the cancer substances.

Which molds are the ultimate living biotics against cancer substance are not yet identified, but research *can* identify them. That is the point of this essay.

For a culture medium, there can be created a *cancer cemetery*. An old abandoned cemetery, partly swampy and partly drained, could be encased by an impervious wall forty feet deep, extending farther down than any form of life goes in the soil.

The topsoil can be enriched by buckets of earth flown to it from old semi-marshy cemeteries, e.g., those in New Orleans, where for a century un-

embalmed bodies have been buried. These buckets of cemetery soil would contain nonspecific cemetery worms and nonspecific cemetery molds. These buckets of soil could be spread on the top soil and covered with spadefuls of the dirt belonging to the walled-in cemetery. Thus the cancer cemetery may be prepared.

To it, from near and far, from surgical cases and autopsies, cancers can be brought to be buried. Breast cancers (not breasts with cancers but cancers dissected from breasts) can be planted in one corner of the cancer cemetery, cancers of the uterus in another area, and still other designated areas, cancers of certain other tissues could be buried. This procedure would be continued for a few years, which would mean many, many generations of cemetery worms and cemetery molds.

Then would come the first step toward identification. Some new breast cancers can be buried in the breast-cancer area, but buried diagonally so that part of the tissue is under the topsoil and part of the tissue is above the surface, exposed to the air. When the tissue is moldy, both the part under the surface of the dirt and the part above the dirt, the molds on it can be identified by a mycologist in his laboratory. Repeated examinations may show that certain strains of molds are generally found on or near breast cancers. They may be cultivated in the laboratory, and in boxes in its yard or greenhouse, on dirt which has been cooked until sterile and mixed with minced fresh breast-cancer tissue. When the molds have become specific against *breast* cancer, they can be cultivated further by ordinary mold-laboratory techniques, and the anticancer biotic fraction extracted for therapeutic use, much as penicillin is extracted from penicillium mold cultures.

Conclusions

1. In nature, in the life history of cancer there is a *natural* end of cancers: *the natural end is not the death bed but is in the cemetery.*

2. The *only* natural source of crude anticancer biotic is in cemetery molds, which have eaten the dead bodies of cemetery worms, which have eaten not only the bodies of persons who died of cancer but also the cancers in those bodies. (Reference is made to unembalmed bodies).

3. A *cancer cemetery,* as described above, used as a culture plate and culture medium, can furnish the crude anticancer molds; and under controlled cultivation in prepared soil, as outlined, these molds can be grown in sufficient quantities to be identified. Recent advances in science, such as penicillium cultures and the culturing of phage to new specificity, open a vista and point out to research the way to culture these anticancer molds until a therapeutic anticancer biotic can be isolated.

4. The refinement of specific anticancer biotics for therapeutic use against specific types of cancer in specific tissues, e.g., carcinoma of the breast, uterus, et cetera, can be done in tiny, synthetic, laboratory *cancer cemeteries,* like a green house.

5. Such a research task is practical now but would be expensive and take time, and would need several well-co-ordinated teams of diversified workers. It would need the co-operation of local hospitals, especially their surgeons and pathologists; the active support of many other doctors, including rural family physicians with their knowledge of rural cemeteries and family histories; and the talents of the mycologists and biochemists of great pharmaceutical and industrial firms.

30 North Michigan Avenue

MSMS

Under the now expiring Emergency Maternity and Infant care program, about $125,000,000 of federal money was spent, of which about $60,000,000 went for hospital care.

THE CORNELIAN CORNER

(Continued from Page 619)

ages the expectant father to accompany his wife on her first visit to the obstetrician and learn directly about her needs during the prenatal period so that he can share her experience with her and understand how to assist her toward becoming a good mother. The sense of well-being and the emotional security of every expectant mother is determined very largely by her husband's attitude.

Through its efforts to have the newborn infant in the same room with its mother from the time of birth, the Cornelian Corner hopes to make it possible for the father of the child to visit as often as he can. It encourages him to hold his infant so that he, too, may begin to love his child as early as possible. The Cornelian Corner is, finally, a mental hygiene project which aims to promote better parent-child relationships.

Postoperative Foreign Bodies in the Abdomen

By Edward S. Zawadzki, M.D. and
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Detroit, Michigan



Edward S. Zawadzki, M.D.



Keith M. Truemner, M.D.

A SPONGE left in the abdomen following an operation usually has unpleasant complications and may be a diagnostic problem in the later life of the patient. This accident is not uncommon. Crossen and Crossen,[1] in an exhaustive review of the literature from 1859 to 1940, found 307 cases, and they feel that these represent but a fraction of the actual number. According to these authors, the symptoms due to a sponge left in the abdomen are variable. Usually they manifest themselves in the immediate postoperative period, although not infrequently they may not occur for months or even years. It is rare, however, that a sponge be retained more than five years. Crossen and Crossen[1] report fourteen such instances. Walker and Coburn[4] report one case where the sponge was found twenty-seven years after operation. We wish to report two cases in which sponges were retained in the abdomen, in one instance for twenty-eight years and the other for twenty-three years.

Case Reports

Case 1.—A sixty-four-year-old white housewife was admitted to the hospital on August 14, 1946, complaining of pain and swelling of the abdomen. In October, 1945, she had an episode of intestinal obstruction which was relieved by medical means. At that time a constricting lesion of the splenic flexure of the colon was diagnosed roentgenologically following a barium enema. She again had episodes of obstruction in March and July, 1946, which were also relieved by medical treatment. Roentgenograms after each episode revealed the lesion of the colon to be progressing. The patient finally agreed to an exploratory laparotomy.

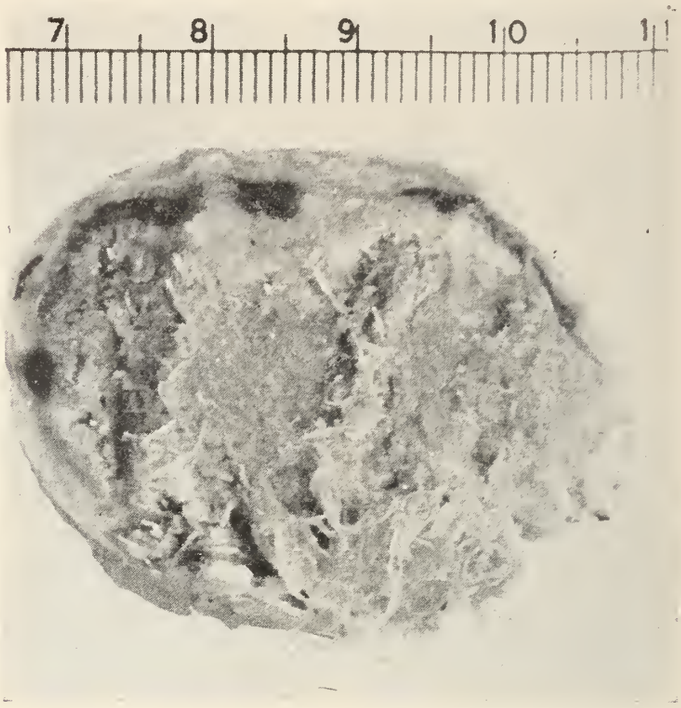


Fig. 1. Encapsulated sponge found in the abdomen of the patient in Case 1.

She had been under treatment for diabetes mellitus since 1940. A dilatation and curettage was performed in 1906 and a hysterectomy for uterine leiomyomata in 1918. There had been no abdominal complaints until the episode of obstruction in 1945.

On physical examination, a hard movable mass was palpated in the left upper quadrant of the abdomen; this was thought to be the obstructing lesion found on roentgenograms.

The abdomen was opened by an upper left rectus incision. A cystic mass measuring 5 cm. in diameter was found related to the jejunum and its mesentery. This was removed but during the dissection the bowel was entered at the point of attachment. It was uncertain whether the cavity of the structure was in communication with the lumen of the bowel. On further investigation the lesion of the splenic flexure of the colon was found, resected, and the intestine repaired by end-to-end anastomosis. The patient made an uneventful recovery and was discharged on September 7, 1946.

The specimen from the jejunum was a somewhat oval cystic mass, 5 cm. in diameter, filled with brownish solid material containing threads or hairs. On section the cyst wall was mottled yellow and red and measured up to 3 mm. in thickness. After the specimen had been in formalin for several days the mesh of a gauze sponge could be recognized (Fig. 1).

On microscipic examination, the cystic mass was composed of a central mass of amorphous eosinophilic

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material in which cotton fibers could be recognized. The wall of the cyst was composed of fibrous connective tissue which was mostly hyalinized. Near this living portion there was calcium deposition on cotton fibers. There were areas of old hemorrhage with cholesterol-

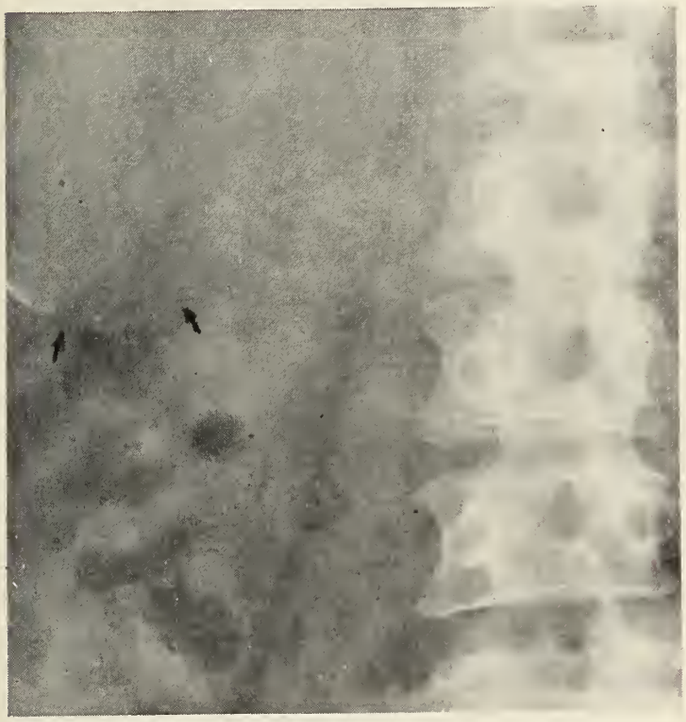


Fig. 2. X-ray shows calcium shadow due to encapsulated sponge in the region of the gall bladder. Case 2.

crystal clefts and surrounding foreign-body giant-cell reaction.

The lesion in the colon was an adenocarcinoma with extension to the pericolic tissues and lymph nodes.

Case 2.—A fifty-three-year-old white housewife entered the hospital on April 22, 1947, complaining of pain in the abdomen after meals, much gas, vomiting, and nervousness. Twenty-three years previously she had an appendectomy and removal of gallstones.

On physical examination there were well-healed ancient right lower and right upper quadrant abdominal surgical scars. No masses or enlarged organs were palpated. There was slight tenderness in the right upper quadrant of the abdomen and in the right costovertebral angle.

Retrograde pyelograms were normal, but with oral cholecystograms there was evidence of a nonfunctioning gall bladder. In the right upper quadrant of the abdomen, in the region of the gall bladder, there was an incomplete circular shadow of calcium density, 5.5 cm. in diameter (Fig. 2).

At operation a large cystic mass was found and removed from the vicinity of the gall bladder. After freeing numerous adhesions beneath this mass, the gall bladder was identified and removed. It contained several small stones. The patient made an uneventful recovery and was discharged May 13, 1947.

The cystic mass measured 14 cm. in greatest dimension and had a fibrous capsule covered by numerous tissue tags. The wall was calcified in areas. Centrally, the cotton fibers of a sponge could be recognized, intermixed with necrotic material (Fig. 3). Microscopically

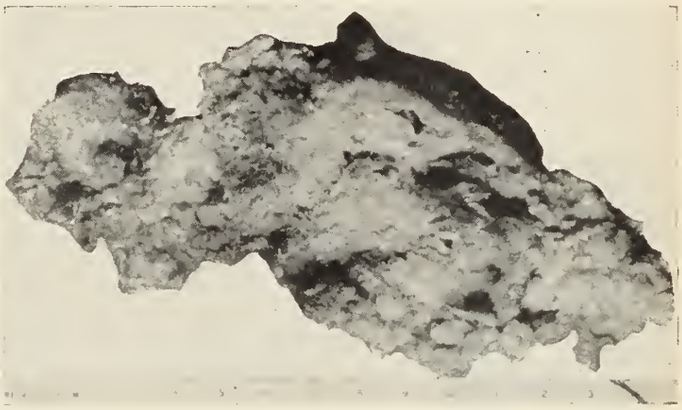


Fig. 3. Encapsulated sponge found in the abdomen of the patient in Case 2.

the wall was composed of dense hyaline connective tissue with areas of calcium deposition along the inner surface. There were numerous phagocytes present along this surface. Within the cavity, cotton fibers as well as necrotic and degenerating material were identified.

The gall bladder revealed chronic cholecystitis and cholelithiasis.

Discussion

In the first case, the sponge was a complete surprise and its nature was not immediately recognized. Its attachment to the jejunum suggested a diverticulum, and its gross appearance at the operating table suggested a dermoid cyst. Only after cross section was its true nature discovered. It is probable that this was the mass palpated prior to operation. The patient did not recall any symptoms that could be ascribed to the presence of this intra-abdominal foreign body.

In the second case, it is possible that some of the abdominal distress of the patient could be ascribed to the foreign body, although a diseased gall bladder was also present. In contrast to the first case, sufficient calcium was present in the cyst wall to be detected radiographically although no specific diagnosis could be made. The sponge was recognized readily at the operating table. It had been present in the abdomen for twenty-three years.

Both cases are unusual in the length of time that the sponges had been retained with little, if any, evidence of their presence. Had these sponges contained radiopaque threads, as advocated by

(Continued on Page 639)

Vertigo

Differential Diagnosis and Treatment

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THE NAME of Ménière has become generally associated with attacks of dizziness or vertigo since the description of his famous case in 1861. The terms Ménière's disease, Ménière's syndrome or symptom complex, and pseudo-Ménière's syndrome are all in common use at the present time. Any discussion of the subject of vertigo requires a definition of what is meant by these terms.

The name Ménière is associated only with that type of vertigo which produces a sense of motion either of the environment or the individual, usually of a rotational character but sometimes in a lateral or downward direction.

It does not apply to the sense of giddiness or dizziness which accompanies certain ocular disturbances or a loss of muscle and joint sense.

After Ménière's original description, the term Ménière's disease was apparently applied to the apoplectic type of vertigo and deafness which occasionally occurred in a previously normal ear. A vascular accident in the labyrinth was considered to be the etiology. Gradually it became apparent that a vascular lesion could not explain the majority of cases of vertigo, deafness and tinnitus, and that undoubtedly several causes were to be considered. The term Ménière's syndrome or symptom complex therefore received general preference, and continues in use as a term which embraces the occurrence of vertigo, deafness and tinnitus in the form of a single or repeated attacks. Suppurative labyrinthitis, acoustic tumors and traumatic injury were usually not included, since the etiology in these cases could be definitely determined. Since the acoustic and vestibular portions of the eighth nerve separate upon entry into the brain stem, the combination of auditory symptoms with vertigo is therefore indicative of a disease or lesion affecting the peripheral labyrinth or eighth nerve.

The term Ménière's disease has again come into common use in reference to one particular clinical group. This group is characterized by recurring vertigo in the form of attacks associated with deafness and tinnitus of a fluctuating type. The pathologic disturbance in this group has been found to be a hydrops or dropsy of the labyrinth (dilatation of the endolymphatic fluid system of the inner ear). Ménière's disease therefore refers to one disease entity which gives rise to the general syndrome of Ménière.

Vertigo is also a symptom of many types of disease of the central nervous system, arising from disturbances of the central vestibular nuclei and pathways. It is therefore a common symptom in disease involving the posterior cranial fossa, and in such cases is usually not accompanied by deafness.

It is also possible that vertigo may arise from a disturbance of the vestibular apparatus in the ear without auditory symptoms. This occurs in the occasional case of labyrinthine dropsy. However, the auditory sense organ is more susceptible to injury than the vestibular receptor apparatus, and it is probably only in rare instances that vertigo is produced by inner ear disease without also having some degrees of deafness or tinnitus or both.

In everyday experience, the occurrence of vertigo in the form of an attack without auditory or other localizing nervous signs is found to be as common as the occurrence of the complete Ménière's syndrome. Such attacks are commonly referred to as pseudo-Ménière's syndrome.

Pseudo-Ménière's Syndrome

Because of the absence of auditory symptoms, vertigo of this type cannot be definitely localized to the peripheral vestibular mechanism. A true Ménière's disease (labyrinthine dropsy) has begun in an occasional case as a pseudo-Ménière's syndrome, the auditory symptoms appearing after a few weeks or months, but such cases are infrequent.

Vertigo without other localizing signs has been sometimes observed as the earliest sign of tumor, multiple sclerosis, or inflammatory disease in the posterior fossa, and may be the predominant symptom of posttraumatic syndrome.

In such cases the diagnosis is made possible by the history or the associated symptoms and signs

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which eventually appear, but certain characteristics of the vertigo appear to be of significance in localization.

It has been found that when the central vestibular system is the site of the disease, the vertigo in the majority of cases is either brought on or greatly influenced by changes in posture, and is therefore known as a "postural vertigo."

The postural character can be brought out in the history. Such patients quickly find that certain positions of the head or certain movements bring on the vertigo, while it may be avoided by keeping the head completely quiet or in certain positions. The vertigo which arises from the vestibular system is accompanied by nystagmus; therefore, the routine test for postural vertigo and nystagmus is likely to be the most revealing part of the examination.

Attempts have been made to classify the types of positional nystagmus found on these routine tests and to localize the origin to the peripheral or central vestibular mechanism on that basis.

It appears that when the nystagmus can be reversed by changing the position of the patient, the disease lies in the central apparatus. However, in cases where a reversal does not occur, but only a reduction or disappearance of the nystagmus, or possibly a slight variation in direction, the sign may not be helpful in localization.

The tests for vestibular excitability are frequently of no value in pseudo-Ménière's syndrome, since they are most often normal, but may be symmetrically reduced or may be asymmetrical responses without giving reliable aid to localization.

The vertigo in pseudo-Ménière's syndrome is of the postural type in the majority of cases, although in some it may be a constant vertigo during the initial severe stage, becoming postural as the symptom abates.

While such diseases as early labyrinthine dropsy, early tumor and multiple sclerosis must always be considered, it is found that the syndrome is due most frequently to other causes affecting the central vestibular apparatus.

These conditions, which appear to explain the vertigo in the majority of these cases, may be grouped as follows:

1. Cerebral arteriosclerosis and hypertension.

2. Toxic manifestation, either of a low-grade infection, probably of the virus type in most instances, or of certain drugs such as alcohol or streptomycin.

3. Vasomotor insufficiency. Under this heading can be included the vertigo that is common at the onset of the menopause as well as the relatively common group in which a single or repeated attacks of postural vertigo seem to be related to an abnormally low or labile blood pressure and other vasomotor disturbances.

The prognosis for relief of the vertigo in such cases is always good, and the matter of localization is fortunately not of grave importance.

The treatment consists in absolute rest, avoiding movement of the head, mild sedation, and treatment of the underlying etiologic factor.

Ménière's Syndrome

The term Ménière's syndrome is not customarily used when an etiologic diagnosis can be made; hence labyrinthitis, acoustic neurinoma, and traumatic injury are not included. However, in some instances the diagnosis of even these conditions may present difficulties. For example:

An attic cholesteatoma with a small perforation in Shrapnell's membrane may produce a labyrinthitis and yet escape detection by the unskilled observer. Or an acoustic neurinoma in the early stage may be confused with hydrops of the labyrinth. Repeated examinations will, however, demonstrate the absence of vestibular responses, the eventual involvement of other cranial nerves, and possibly dilatation of the internal auditory meatus on roentgenographic examination in the case of acoustic neurinona or cerebellopontine angle tumor.

Trauma of the head, with or without fracture, may result in concussion of the inner ear on one or both sides and the onset of profound loss of function, which comes on some hours after the injury. Recovery is usually incomplete and may require several weeks. It is known that in animals subjected to measured blows on the head, free hemorrhage occurs into the tissues of the modiolus and to some extent in the fluid spaces of the inner ear; hence, the disturbance of function may be related to hemorrhage.

Those conditions which are sometimes included under Ménière's syndrome in its present interpretation include the following:

1. Labyrinthine fistula. Cholesteatoma in the attic and aditus is the common cause, but the symptom is common in congenital syphilis which

involves the ear, and may occur in rare cases of granuloma or tumor of the temporal bone. It can be detected by the production of vertigo and nystagmus on increasing and decreasing the air pressure in the external auditory meatus.

2. Nonsuppurative otitis media is also a relatively rare cause for an attack of vertigo. The acute or subacute tubal blockage with exudative catarrh (middle ear completely filled with fluid) sometimes is associated with vertigo, which may be relieved by incision of the drum and removal of the fluid by tubal inflation.

3. Toxic neuritis or neuro-labyrinthitis. The cochlear apparatus is more sensitive to toxic processes than the vestibular sense organs; hence, severe damage to the auditory mechanism may be produced with relatively little vertigo. The deafness which sometimes follows mumps is a classic example of a toxic neuritis. Fortunately, it is nearly always unilateral. Vertigo may be present for a few days at the onset but vestibular function is not impaired. A similar toxic degenerative type of deafness may follow other acute infectious diseases. Deafness and vertigo may accompany a geniculate ganglionitis and may occur in a polyneuritis of infectious origin associated with parotitis and uveitis.

A number of drugs have been know to bring on tinnitus, impaired hearing and vertigo. Quinine, salicylates, tobacco in rare cases, and streptomycin in large dosages are examples.

4. Hemorrhage and thrombosis. Hemorrhage has been found in the fluid spaces of the inner ear in some cases of advanced leukemia. The original case reported by Ménière probably belongs to this group, since the death of his patient was otherwise not explained.

The sudden onset of severe tinnitus, deafness and vertigo in a previously normal ear, with resulting gradual recovery from vertigo but a profound and permanent impairment of hearing, is occasionally seen in people of the fourth decade of life or later. Such a single episode, occurring without evidence of infection or demonstrable systemic illness, suggests some type of vascular lesion as the most probable explanation. Histopathologic proof is still lacking. Such attacks do not recur. They may be of varying severity. In some cases there is profound deafness. In others the resulting deafness may be less profound, and in some of these the vertigo has been known to persist for several years when the patient assumed certain positions. Some cases are seen where vertigo does not occur, but deafness and tinnitus appear in the same sudden manner, and a permanent nonprogressive high-tone deafness may result.

It appears likely that these different degrees of impairment represent variations in the same type of inner ear pathology.

5. Allergy. The occurrence of deafness and vertigo has been observed along with an acute allergic reaction and may be recurring. The way in which the inner ear is affected is not definite. The question arises as to the relation of an allergic reaction to labyrinthine dropsy (idiopathic Ménière's disease), but on clinical observation there is little evidence to associate the two. The treatment consists in recognition of the allergen and elimination or desensitization.

6. Labyrinthine dropsy (Ménière's disease). The majority of cases of Ménière's syndrome fall into this group. The clinical characteristics are recurring attacks of vertigo, associated with tinnitus and deafness.

The vertigo varies in severity and duration. The onset may be sudden or gradual, either without warning or preceded by steadily increasing deafness, tinnitus and a feeling of blockage in the ear. The attacks may be frequent or infrequent. They may occur several times weekly and disappear for months at a time without evident reason. There is excellent evidence that some patients with the disease may not get the vertigo but have only the characteristic type of auditory disturbances. The hearing impairment associated with hydrops starts as a low-tone loss for both air and bone conduction. Fluctuation in the threshold occurs from week to week, sometimes as much as 35 decibels variation occurring within a day or two. The disease appears usually in the fifth decade, but may appear earlier or later. In about half, the occurrence of hydrops with vertigo and low-tone deafness is preceded by bilateral high-tone progressive deafness. In younger people, however, the disease appears without pre-existing high-tone deafness. The hearing loss tends to be progressive, and in more advanced stages high-tone thresholds are reduced along with those for low tones. The deafness may become profound within a few years or may decrease more slowly. Noises are troublesome, and are usually a low-pitched roaring type, varying with the deafness. An intermittent dipla-

cusis or an unpleasant disturbance of pitch perception is common. Bone conduction is reduced along with air conduction and fluctuates with it. The Rinne test remains positive.

The condition is unilateral in the majority but bilateral in from 10 to 15 per cent.

The tests for vestibular function are usually about normal in early stages, but a gradual decrease in caloric response is usually found in advanced stages. The responses may also be greatly reduced at one testing and normal at a later examination.

A postural effect on the vertigo may occur and, when present, consists usually of an increase in vertigo and nystagmus in certain positions. The direction of the nystagmus varies little, however, in contradistinction to most cases of pseudo-Ménière's syndrome.

The pathologic condition in the inner ear consists in a dilatation of the endolymphatic fluid system. The dilatation is irregular because of the variations in thickness of the membranous walls, and varies somewhat from case to case. The sensory organs which are located within the endolymphatic system are affected by the physical distortion of the structures, probably also by pressure changes, and in late stages some degenerative changes are found in the neural apparatus. The etiology and pathogenesis remain obscure as yet. However, the most likely explanation is that the increase in quantity of endolymph is due to some disturbance of the secretory mechanism. No sign of inflammatory reaction is evident, with no cellular infiltration, and no change in the staining characteristics of the fluid.

The tendency for Ménière's disease to be associated with headaches, and in younger age period with low blood pressure and gastrointestinal complaints suggests a vasomotor disturbance in the ear as a causative factor.

Treatment

Medical

The medical treatment which seems to give best results is directed toward maintaining an even fluid balance and preventing temporary increases in the amount of endolymph. Such measures as restriction of fluid, a salt-free or sodium-free diet and the use of mild diuretics appear to be indicated.

The sodium-free diet recommended by Fursten-burg, Lashmet and Lathrop, accompanied by ammonium chloride, 6 to 9 gm. daily for alternate three-day periods, has given fair results.

The ammonium chloride is given during each meal in equally divided doses for a period of six weeks, repeating the course in alternate six week periods.

A low salt diet accompanied by potassium chloride, two teaspoonfuls of a 25 per cent solution twice daily with the meal, as introduced by Talbot and Brown, has been found practical and useful.

Better results are obtained if the medical treatment is accompanied by attention to the patient's habits. Even distribution of the food and fluid intake during the day, reduction in the working hours, adequate time to rest and mild sedation are helpful.

Inflation of eustachian tubes in cases of labyrinthine dropsy has not been of value.

Histamine therapy has been widely used. Intravenous injection of histamine according to Horton's method, 2.75 mg. of histamine diacid phosphate in 250 c.c. of normal saline in a period of one and a half hours or more, has been useful in relieving an attack of vertigo. The effect appears to be in some way due to the vasodilator effect of histamine.

I have not been able to satisfy myself that subsequent attacks could be prevented by subcutaneous injections of histamine several times weekly.

The theory that a patient may be desensitized to histamine seems to have been refuted.

Nicotinic acid has also been a popular method of therapy.

Many drugs have been used for treatment of this disease, including atrophine, pilocarpine, epinephrine, and saline laxative. The antihistamine drugs, benadryl and pyribenzamine, do not appear to have produced definite results as yet. The general experience has been that the attacks of vertigo could be more or less alleviated in the majority of cases by medical treatment.

Patients are more concerned with the prevention of vertigo than with the auditory difficulty, unless both ears are involved, when the deafness may become a serious handicap.

In about 10 per cent of cases, because of failure of medical therapy and the hazard involved in certain occupations in case of vertigo, some form of surgery is justifiable.

Surgical

1. Intracranial section of the vestibular portion of the eighth nerve was introduced by McKenzie of Toronto and has since been carried out on a large series of cases by Dandy. Although the operation is ideal in that the auditory division of the nerve is spared and reported results have been good, the operation has not been free from complications, and the tendency on the part of most neurosurgeons seems to be to reserve it for carefully selected cases.

2. Various surgical procedures have been performed on the labyrinth for this condition.

Portmann's operation, opening the endolymphatic sac, has given only partial success. Experiments indicate that the operation has no rational basis.

Injection of alcohol into the labyrinth destroys hearing as well as preventing the attacks of vertigo, but has also caused a facial palsy.

A labyrinthotomy with destruction of the endolymphatic labyrinth either by evulsion, instrumentation or coagulation within the canal and vestibule, has proven to be a simple and safe way of preventing further vertigo. However, the hearing has been destroyed in almost all cases. The operation is not suitable therefore for the bilateral cases but has been satisfactory from the patient's viewpoint in unilateral cases, since the hearing had already been greatly depressed before operation.

Varying degrees of relief from the noises in the ear have been obtained.

Summary

1. Attacks of vertigo of the type which arises from the vestibular apparatus are usually associated with the name of Ménière.

2. The terms Ménière's disease, Ménière's syndrome or symptom complex, and pseudo-Ménière's syndrome are defined.

3. The differential diagnosis in the presence of pseudo-Ménière's syndrome is discussed.

4. The various inner ear conditions which may produce Ménière's syndrome or symptom complex are discussed.

5. Labyrinthine dropsy or Ménière's disease, which is the most common cause of Ménière's syndrome, is discussed in some detail.

MSMS

Hemometakinesia

Therapeutic Application to Peripheral Vascular Disease

By Michael E. DeBakey, M.D., George E. Burch, M.D., and Thorpe Ray, M.D.

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M. E. DeBakey, M.D.

THE CONCEPT of hemodynamics, to which the term hemometakinesia has been applied, provides, it is believed, a more rational approach to the management of certain forms of peripheral vascular disease than now exists.[5,9] This concept is based on certain observations concerning the physiology of the circulation which established the presence of spontaneous and even rhythmic fluctuations in the volume of organs, primarily attributable to changes in the volume of the blood within the part. These observations, which suggest that there is a continuous shifting back and forth of blood from one part of the body to another, seem to indicate the existence of a well regulated "borrowing-lending" mechanism which permits the body to utilize its limited blood volume in the most effective manner to meet variations in local requirements.

To permit a better understanding of this new concept and of its therapeutic significance in peripheral vascular disease, it is necessary to outline briefly some of the studies and observations which have led to its formulation.

It has been a well-established fact for a long time that the volume of organs undergoes spontaneous and even rhythmic variations, which are attributed essentially to changes in the volume of the vascular bed of the part and which thus reflect variations in the behavior of the local circulation. With the recent development of more refined techniques of plethysmography, it has been possible to make more precise quantitative studies of the fluctuations in volumes in such peripheral

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parts as the fingers, toes and pinnae. These studies have contributed much useful knowledge of the mechanisms of the peripheral circulation in health as well as in disease.

It has been demonstrated by means of the plethysmograph that spontaneous variations in volume occur in the small blood vessels of such peripheral areas as the pinnae, fingers and toes.[1,2] At least five types of rhythmic changes in volume, ranging from less than 0.1 to 350 cu. mm. or more per 5 c.c. of part, have been noted in the normal person resting in comfortable surroundings, as follows:

1. Pulse deflections, which represent the changes in volume of the part produced by the blood delivered into the part with each heart beat.

2. Respiratory deflections, which represent variations in volume (from less than 0.1 to 5 cu. mm. per 5 c.c. of part) occurring with the normal respiratory cycle. They are chiefly contingent upon variations in venous return to the heart produced by respiration.

3. Alpha deflections, which are primarily controlled by the sympathetic nervous system although they are independent of variations in arterial pressure. They occur less frequently than respiratory deflections. They usually have smooth, though not necessarily uniform, contours, and they vary in frequency and size, with a tendency toward an inverse relationship.

4. Beta deflections, which are larger changes in volume upon which a succession of smaller alpha deflections is superimposed. They vary in volume from 5 to 60 cu. mm. per c.c. of part and they have a frequency range of from one to two per minute. Although they possess a totally irregular frequency and volume, they tend to vary concordantly in the fingers, toes and pinnae.

5. Gamma deflections, which are probably concerned with large and usually comparatively slow shifts in blood from one part of the body to another. They develop more slowly than any of the other deflections; they vary in frequency from one to eight per hour and in volume from 50 to 350 cu. mm. per 5 c.c. of part. They are primarily due to changes in volume of the vascular bed of the part, with variations in lymph volume probably contributing significantly to the volume change.

The different types of volume deflection observed in the normal plethysmogram may be affected by a number of factors. These factors produce variations of considerable degree, which may resemble the changes found in diseased states. Among the factors which may produce changes reflecting the behavior of the peripheral circulation in response to external and internal stimuli are the psychic state of the individual, the environmental temperature, the relation of the part to heart level, and the presence or absence of intact sympathetic pathways to the part.

The psychic state of the individual affects particularly the pulse and alpha deflections, probably as a result of increased sympathetic activity. Thus, fear, anxiety or tension tend to diminish the pulse and alpha deflections and to increase the rate of the pulse deflections.[3,6]

Changes in environmental temperature may profoundly affect the spontaneous volume deflections. Thus, chilling, by producing vasoconstriction, reduces the volume of the pulse and the alpha deflections and, if it is prolonged, may cause the occurrence of a negative gamma deflection, which indicates a decrease in the volume of the part. Heating, on the other hand, produces vasodilatation, with a consequent increase in the volume of pulse deflection. After full vasodilatation, the increase in the volume of pulse deflection is followed by a decrease in alpha deflections, and then by a positive gamma deflection, indicating an over-all increase in the volume of the part. These reactions are a good guide to the diagnosis of organic occlusive arterial and arteriolar disease, since vasodilating responses are impaired or absent in patients with such conditions as thromboangiitis or obliterating arteriosclerotic endarteritis. The effort to produce vasodilatation in the tips of the fingers or toes by the application of heat to another extremity tests the patency of the arteries and peripheral blood vessels to the part under investigation, as well as its neurovascular mechanism.

Spontaneous volume deflections are also influenced by the position of the part in reference to the heart level. If the part is placed below heart level, there is a decrease in the volume of pulse and alpha deflections. A positive gamma deflection is produced by the pooling of blood and lymph in the dependent part as the result of gravity. Arteriolar constriction, either alone or in combination with distention of the vessels secondary to increased venous pressure, with a reduction in further distensibility of the vascular wall, has been suggested to explain this phenomenon.[4] The opposite effect

is obviously obtained by raising the part above heart level. To obtain standard recordings, therefore, the part should be maintained at or near heart level.

Finally, interruption of the sympathetic pathways will alter spontaneous volume deflections. The volume of the pulse deflections, for example, increases considerably and the alpha deflections virtually disappear within a few minutes after infiltration of 1 per cent solution of procaine hydrochloride into the regional sympathetic nerves or ganglia. A large positive gamma deflection is produced by engorgement of the vascular bed within the part after sympathetic block. By means of sympathetic block, therefore, it is possible to determine the degree of the normal, or, in certain conditions, of the abnormal, vasoconstrictor tone and the extent of vasodilatation or the general order of the amount of increase in vascularity of the part that can be achieved by interruption of these pathways.[7,8]

On the basis of these plethysmographic observations, as well as on the basis of other studies showing comparable changes in the volume of certain internal organs, it is evident that spontaneous variations are constantly occurring in the volume of the vascular bed in different parts of the body. These fluctuations may be rhythmic, concordant, or discordant, and they are apparently influenced by a number of factors. They suggest a continuous shifting of the blood from one part of the body to another, a sort of "borrowing-lending" phenomenon, to meet local requirements. Certainly they reflect a well-regulated mechanism which seems to be concerned with vital physiologic adjustments and which seems to have definite order and significance.

It seems reasonable to assume that at least a part of the possible significance of these changes lies in an attempt by the body mechanism to make the most efficient use of the total blood volume in meeting the variable requirements for blood for different parts of the body. The total blood volume is too small to meet the maximum demand of all the tissues at the same time, but it is more than adequate to accommodate isolated parts urgently requiring large quantities of blood at certain times. Under normal conditions the total blood volume is relatively constant, although considerable variation in the vascular bed, especially in isolated parts of the body, can occur within a comparatively short time. Within a matter of minutes the volume of the vascular bed in a certain part of the body, such as a finger or a toe, may be observed to increase greatly, sometimes to as much as double its original size. Obviously, the additional blood required to fill the augmented vascular bed must come from some source. Since the total blood volume is relatively constant, it seems reasonable to believe that the local increase was taken from the bed of some other part or parts of the body. If the volume of the vascular bed in one part of the body is increased by a certain amount, and if the volume of the bed in other parts of the body is simultaneously decreased by the same amount, no change is required to take place in either the blood volume or the cardiac output. The only change required to achieve this purpose is an adjustment in the vascular beds of different parts of the body.

What occurs, in other words, is actually a borrowing of blood in one part of the body and a lending of blood in other parts. This phenomenon constitutes the essential features of the concept of hemometakinesia. The essence of the mechanism seems to lie in the control and regulation of the vascular bed which permit an increase in the volume of blood of one part of the body and a corresponding simultaneous decrease in the volume of blood of other parts. It should be realized that the amount contributed for lending purposes by individual parts of the body may be relatively small. The major part probably comes from the larger vessels within the organism, though all the vessels may participate in the contribution.

This borrowing-lending phenomenon has been repeatedly demonstrated in normal persons as well as in patients with peripheral vascular disease by thermometric and plethysmographic studies under controlled atmospheric conditions, in a room built to reduce psychic disturbances.[5,9] Illustrative cases have been cited in previous publications.[5,9]

Therapeutic Implications of Hemometakinesia

The principles of hemodynamics which constitute the basis of the concept of hemometakinesia are thought to have a direct therapeutic application to peripheral vascular disease. In such conditions there is a reduction below normal in the mount of circulating blood to a part. Therapy, to be effective and to provide improvement in the local circulation, must obviously be directed toward securing an increase in the blood supply to the part. This objective requires an increase in the

volume of the vascular bed of the part, which can be achieved by vasodilatation.

Various measures have been proposed for this purpose, but most of them, including, in particular, drugs and chemical agents administered systemically, produce varying degrees of generalized vasodilatation. In most peripheral vascular disturbances, however, the diminution in circulation is localized to one or two peripheral parts, and the primary objective of therapy is to provide maximum vasodilatation in these localized areas of involvement.

In the light of the principles of hemodynamics just described, it appears irrational to employ therapeutic measures designed to produce dilatation of the entire vascular bed in conditions in which the diseased state is localized to one or two peripheral parts. Moreover, their efficacy is dubious. The possible production of maximum generalized vasodilatation would create a serious disproportion between the augmented total volume of the vascular bed and the relatively fixed total volume of blood. Indeed, since the total blood volume is relatively fixed, the only means by which it becomes possible to increase the circulating blood volume in any localized area when there is a comparable increase in the entire vascular bed is by an increase in cardiac output, the desirability of which is decidedly open to question.

The therapeutic approach which conforms best with the concept of hemometakinesia consists in the production of local vasodilatation limited essentially to the part in need of more blood. This is best achieved by interruption of the sympathetic pathways to the affected part. Both in theory and in practice this is the most effective method of producing a maximum increase in the blood supply to the diseased part. In an extensive experience, which covers many years, there has yet to be found a general vasodilator which can produce in a local peripheral part vasodilatation equal in degree or duration to that produced by sympathetic denervation of the part. Other measures may produce varying degrees of transitory increase in the blood supply of a diseased part, but sympathectomy is the only means by which a maximum and relatively permanent improvement in the local circulation can be effected.

Summary

Plethysmographic observations and other studies indicate that spontaneous variations are constantly occurring in the volume of the vascular bed of different parts of the body. The term hemometakinesia has been applied to this continuous shifting of the blood from one part of the body to another, which is, in effect, a sort of "borrow-lending" mechanism to meet varying local requirements. The therapeutic implications of this new concept of hemodynamics are particularly applicable to peripheral vascular disease. They support the belief, already thoroughly tested by clinical experience, that although other measures may produce varying degrees of transitory increase in the blood supply of a part, which is the objective of the therapy of peripheral vascular disease, sympathectomy is the only means by which maximum and relatively permanent improvement in the local circulation can be effected.

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MSMS

FOREIGN BODIES IN THE ABDOMEN

(Continued from Page 631)

Lewison,[2,3] they could have been recognized preoperatively and perhaps many years sooner.

Summary

Two cases of intra-abdominal foreign bodies (gauze sponges) are reported, the first of twenty-eight years and the second of twenty-three years' duration.

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Editorial

DOCTORS FOR THOSE EMERGENCIES

THE PROGRAM of the twenty-first annual meeting of the National Conference on Medical Service, held in Chicago, February 8, 1948, was featured by a paper entitled, "Medical Public Relations Begin in the Doctor's Office" given by L. Fernald Foster, M.D., Bay City, secretary of the Michigan State Medical Society, which was very energetically received. This discussion started a series of editorials in the *Journal of the American Medical Association,* calling attention to certain failures of the profession in maintaining service of doctors for the public at all times, even though the doctors of a community are in the habit of taking a day off once a week. (Which is one day *less* than most workers take per week.)

It was suggested that registries be established where patients may secure doctors in case of emergency, when their own doctor is not available. This has been done in many communities, some of the doctors staying on call while the others are away. Moreover, medical men have been assigned to athletic contests so that care for injuries is immediately available. In other places, doctors have remained on call at the hospitals for night emergencies. Doctors have also been requested to stagger their days off, and to take especial precautions for patients whom they have reason to believe might need attention. In one city, local papers carry advertisements stating what doctor will be on duty. All these efforts are being made, but still the complaint comes that doctors do not answer calls, especially at night, and that they insist on seeing patients by appointment, then have their appointment dates filled for three to six weeks in advance. We have mentioned all these features which Dr. Foster stressed in his talk. It is gratifying to note that almost every State Medical Society journal has copied or quoted the American Medical Association editorial within the past few months.

When the American Medical Association release arrived, one of our newspapers called us to ask whether anything was being done locally in behalf of that anxious patient. We were pleased to report measures to meet the program.

These remarks are in the nature of inviting our attention to the needs of the patient when he is sick. He needs a doctor when he is ill—not two weeks later.

Our congratulations to a medical profession which is ever striving to render a better and more complete medical service. We are proud of our membership.

THE CORNELIAN CORNER

ONE OF THE PAPERS published in this issue presents a different approach to the problem of care for the not-normal person. The description of the Cornelian Corner is worthy of consideration, and gives promise of advance in psychiatry. It is a well-presented paper and has a great deal of merit. In evaluating the factors that enter into the personality make-up, no mention is made of what we like to speak of as differences in constitutional endowment. In other words, human beings to use the language of the street, also fall into the category of "there are different breeds of cats."

The Cornelian Corner argues that environmental factors largely outweigh constitutional endowments. They can undoubtedly influence them largely but constitutional endowment cannot be disregarded. With this thought in mind, we have asked the president of the Cornelian Corner to make a statement on that subject which is here presented in the following signed editorial.

HEREDITY

NO ONE can deny the presence of a constitutional factor in each individual. It is the present-day consensus, however, that environmental influences largely outweigh the constitutional endowments in the etiology of most mental disorders. According to Freud, who stressed the importance of heredity throughout his writings, the constitutional element only becomes an etiological factor in the development of mental illnesses when it is activated by the environmental influences. The most important of these influences are the psychological traumata of infancy and early childhood. Severe and persistent frustration of the instinctual satisfactions is an example. When the

(Continued on Page 642)

Welcome to New Members

During the month of April, a membership campaign was carried on in each of our fifty-five county medical societies. The response to this campaign was enthusiastic. A total of 260 new members has been certified. Some of our county societies boast 100 per cent membership. It is hoped that all county societies will approach this figure.

The advantages of membership in your county medical society are legion. I shall list only a few of them.

1. Automatic membership in the Michigan State Medical Society and the American Medical Association.
2. Opportunity for maintenance and constant improvement of your standards of medical practice for the protection of patients.
3. Increased protection against state and national legislation inimical to public interest and the advancement of medical science; and concerted efforts toward beneficial health measures.
4. Information and technical advice in medical-legal matters.
5. Closer association socially and scientifically with your colleagues in medicine who are interested in the same vital problems that you are.

To all new members, I extend a most hearty welcome and an urgent invitation to take an active part in the affairs of the Michigan State Medical Society. To those few Doctors of Medicine who, because of careless or questionable methods of practice, are not now priviliged to qualify for membership, I express a sincere wish that they may see fit to so change their ways as soon to become eligible for and active in organized medicine—one of the truly great organizations of this country.

P. L. Sedwick

President, Michigan State Medical Society

President's



Page

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psychological care of the child is quite satisfactory the constitutional element remains latent. In some children this inherited disposition is very strong while in others it is much weaker. This explains why one child will be seriously affected by the same experience which would produce only a minor disturbance in another. Freud was of the opinion that when psychotherapy is effective, or the patient recovers from his illness because of other reasons, the hereditary component in his personality again becomes latent. It is now generally accepted that too much has been attributed to the role of heredity and that insufficient attention has been paid to the acquired factors in mental disorders. This has been responsible for the therapeutic pessimism which has been so widespread. It is no longer a question of whether a given illness is hereditary or acquired but how much the constitutional factor has been responsible and how much the environmental influences have contributed to its development. In every instance it is a combination of both of these etiological factors, with emphasis on the environmental influences.

JAMES CLARK MALONEY

THE RED CROSS BLOOD PLASMA PROGRAM

WHEN it became known that the American Red Cross contemplated the establishment of a nation-wide blood procurement program, the Council of the Michigan State Medical Society appointed a committee to investigate the possibilities of applying such a program to the needs of the public, and to the hospitals of Michigan. On two occasions, this committee has met with Raymond F. Barnes, M.D., Director of Medical and Health Services for the Midwest Area of the American Red Cross, who was asked to discuss plans on a national basis. He recounted the Red Cross policies as follows:

"Except for one or two small community registries maintained by American Red Cross Chapters for the purpose of furnishing voluntary donors in emergency, the American Red Cross was not engaged in any blood donor program previous to World War II.

"When it became evident that this country would become involved in the war, there was no blood source available to the armed forces. It was evident that blood, at least plasma, would be needed in large quantities and this organization was asked to obtain it from the citizens of this country. The result was 13 and a quarter million pints.

"When hostilities ceased, the American Red Cross had become so nearly synonymous with blood procurement, that the question naturally arose as to whether the organization should continue to function in the blood procurement field for civilians as it had for the armed forces. Our central committee, the then governing board, as well as others who were responsible for the program, were hesitant at first to enter into a civilian program. The desire to serve was somewhat offset by numerous doubts. Would the people support it? Would the physicians of the country, national, state, and county medical groups want American Red Cross to assist? Could it be done without interfering with the programs of existing institutions or the established prerogatives of the practicing physicians? Could we have the wholehearted support of physicians and accredited hospitals? These and other questions caused hesitancy until early in 1947, when the American Red Cross laid them squarely before representatives of the American Medical Association, the American Hospital Association, the Catholic Hospital Association, the United States Public Health Service, and the Surgeons General with the request for advice as to procedure. A civilian blood program for American Red Cross was approved in principle by all of these groups and hence in June by our own Board of Governors. A national program was then decided upon and since that time Admiral Ross T. McIntyre has assumed its administration.

"American Red Cross Chapters have for some time previous to this decision, been encouraged to enter into community blood donor programs if requested by their local society and several have done so. In each case, only after full approval of their local medical, hospital, and public health groups. In each case, only in an assisting capacity with the medical group actually sponsoring the plan. Never in any case unless the local physicians desired such a plan and co-operated fully in it. No Chapter goes out ahead of its local medical group.

"In the national program, we have been assured that no community will be considered for a blood donor program unless the physicians of that community are wholeheartedly behind it and want it. It would be poor reasoning indeed to believe that any program could succeed nor would this organization attempt to make it succeed unless it was backed by the physicians and the hospitals of that community. The whole national plan is to assit the citizens, the doctors, and the hospitals."

At the present time, it is contemplated that such a program will be established in Ingham County, with the Michigan Department of Health Laboratory contracting to prepare the blood for use as plasma and other blood products, such as: serum albumin, immune serum globulin, antihemophiliac globulin, blood grouping serum, fibrin films and thrombin, red cell suspensions, and red cell paste and powder. A certain proportion will be reserved for use as whole blood transfusions.

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The Journal, M S M S

Historical Review

Many a doctor now living remembers receiving his first copy of THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY that September of 1902.

Few in the profession doubted the wisdom of the step made by the Michigan State Medical Society in starting its own publication. Fresh winds were blowing across America. The spirit of organization was riding that wind.

In Michigan this spirit had been early. It had resulted in the establishment of the county medical societies as branches of the MSMS, implementing the work of the parent organization.

The spirit needed flesh and a skeletal structure.

In the Beginning

Leartus Connor, M.D., recognized this when, at the height of the State Society meeting in Mt. Clemens in 1896, he announced that, in the following year, he intended to move the appointment of a committee "to consider the propriety and wisdom" of publishing the work of the Society in a medical journal controlled by the Society itself.

In his president's address before the Society, June 26-27, 1902, Doctor Connor suggested that a specific resolution be offered to direct the publication committee to issue transcripts in the form of a monthly journal to be known as THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY.

Dr. Connor had his groundwork well laid. Scores of medical men had helped him lay it, offering valuable suggestions since the idea had first glimmered six years before.

One of the key ideas was that of the naming of a committee of four members to serve as a board of publications. All matters relating to the expenditure of funds were to be referred to it; the JOURNAL's management was its responsibility.

So the new century saw the advent of a new publication—of, by and for the men and women of Michigan's medical profession. It has grown to be more than that. The important advances chronicled in its pages are watched by alert editors of newspapers and general publications even beyond the borders of the state.

The Presses Roll

Volume I, Number I was issued in September, 1902. It carried $2,500 worth of advertising—no mean item in assuring the continued life of the infant JOURNAL, and getting its message across to all members of the profession.

Knitting the structure of the county medical societies more closely was one of the first and primary objectives of THE JOURNAL. No one knew this better than the publication's first editor, Andrew P. Biddle, M.D., of Detroit.

Dr. Biddle was an editor in the Dr. Connor tradition. Like the man who had fathered THE JOURNAL, his work was a labor of love. He devoted every possible moment to it, aside from his duties as Secretary of the Society. His four years of constructive effort gave THE JOURNAL a flying start.

THE JOURNAL was published by a small printing house in Detroit in those formative years. During this period the publication of THE JOURNAL was placed under the direction of the Council, where it still remains.

Wilfrid Haughey, M.D., of Battle Creek came upon the scene in 1910, when he was named editor of THE JOURNAL and Secretary of the Michigan State Medical Society. He moved the publication offices to his own community, where it was printed for two years. During his third year THE JOURNAL was printed on the American Medical Association press in Chicago, the advertising policy and contracts having been altered to conform with the standards of the newly established Council on Pharmacy and Chemistry.

Following Dr. Benjamin R. Schenck of Detroit as editor, Dr. Haughey found his hands full. The publication was growing along with the organization it served. It was during Dr. Haughey's first three-year term as editor that No. 100 of THE JOURNAL rolled off the presses. At that time a "very special effort" was made to collect and publish pictures of all past presidents of the State Society, he recalls.

Editor Haughey, M.D.

Dr. Haughey's life has been anything but dull. A bachelor of arts at the University of Michigan; master of arts at University of Detroit; doctor of medicine at Wayne University and F.A.C.S., he has practiced in Battle Creek since his graduation in 1906. His first decade of service was in an office with his father, who was secretary of The Council of the Michigan State Medical Society during the initial ten years following its inception.



The Haugheys, father and son, were key men in the early years of the MSMS and THE JOURNAL.

And now we find Dr. Wilfrid Haughey again at the editorial helm of THE JOURNAL, a living tradition! For the present Michigan State Medical Society had its beginnings in 1866, when the senior Haughey began his career as secretary with the formation of the Council group.

Holding a medical reserve commission, the younger Dr. Haughey answered the call to the colors and served eighteen months in France during World War I. He served twenty-one years as a lieutenant-colonel in the reserves.

Holder of certificates of the Boards for both ophthalmology and otolaryngology, he is chief of the Eye, Ear, Nose and Throat Department of Battle Creek Sanitarium; has served as chief of staff for Leila Y. Post Montgomery Hospital for several years, and is currently on the staffs of both Leila and Community Hospitals.

For a period of about eleven years, Dr. Haughey served as secretary of the Calhoun County Medical Society. He was organizer of the Southwestern Michigan Tri-logical Society and occupied the offices of both secretary and president. He also became president of the Calhoun Society.

That's a full life by any standards—but it isn't all. Dr. Haughey was secretary of the MSMS when it was incorporated in 1910. As such he signed the charter. He signed the present charter in 1941.

Dr. Haughey's first term as editor of THE JOURNAL ended in 1913, when Dr. Frederick H. Warnshuis of Grand Rapids was elected editor and secretary of the Society. World War I interrupted Warnshuis' term abruptly. The work was taken over by Dr. Burton R. Corbus, who served about a year.

It was at this juncture that the offices of secretary and editor were separated. The jobs were too big for any one man.

Dr. James H. Dempster of Detroit stepped into THE JOURNAL editorial picture, followed in 1939 by Dr. Roy H. Holmes of Muskegon.

Once again a world war interrupted an editor's career. Dr. Holmes entered service—and Dr. Haughey stepped back into harness. He was serving as chairman of the publication committee at the time the Japanese attempted to promote their "Co-Prosperity Sphere," late in 1941. He was elected editor at the expiration of Dr. Holmes' term in January, 1943. He's been there ever since.

During this period covering the life of the official organ of the Michigan State Medical Society, THE JOURNAL has not missed a month of publication in forty-seven years—an unusual record. This June number is No. 568.

Journal Content

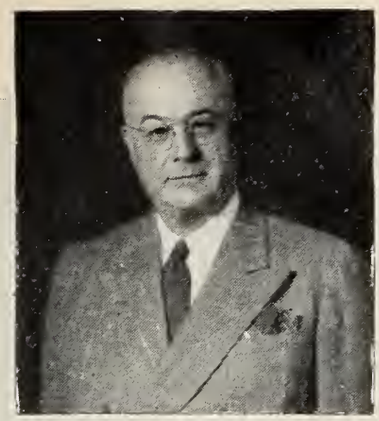
Virtually all of the papers presented at State Medical Society meetings have been printed in THE JOURNAL. Its scope has gone beyond that. Hundreds of papers offered at other sessions—county, district and special—have appeared in these pages. And there have been the numerous papers specially prepared for this publication by members of the profession desiring to impart their findings.

Every publication has its editorial policy. The policy of THE JOURNAL has consisted simply of

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The life cycle of THE JOURNAL—from editor to reader—is shown at the right in a picture story of the major processes involved in the publication of each issue.

All written material to be used in THE JOURNAL is sent by the editor to the publishing company, where a copy editor checks grammar, punctuation, spelling, et cetera, and marks the copy with printing instructions. The material is then set in type by a linotype operator (1), after which his handiwork is checked against the original copy by proofreaders (2). Display type for each article's title is prepared with a special type-casting machine (3). When all material has been initialed "OK" by authors and editors, the type is made up into page-form to correspond with a "dummy" layout (4), and the pages of type are locked in large steel forms (5) to go on the presses. The cover for THE JOURNAL is printed on a small vertical press (6), while the forms for the magazine's pages are placed in huge horizontal flatbed presses and printed on large sheets of paper (7). In the bindery the large sheets are folded, again and again, by an automatic folding machine (8). The folded sections are then assembled in proper sequence, the cover is added, and the magazine is stitched together—all in a single continuous process on a special "gang stitcher" (9). Bundles of magazines then have their edges trimmed simultaneously by the razor-sharp knives of a trimming machine (10). The final task belongs to the mailing department (11), which sends to each reader his month's copy of THE JOURNAL.






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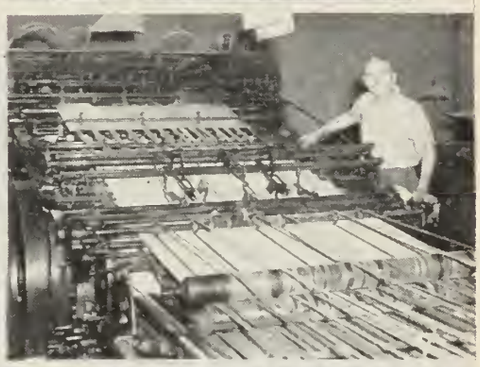

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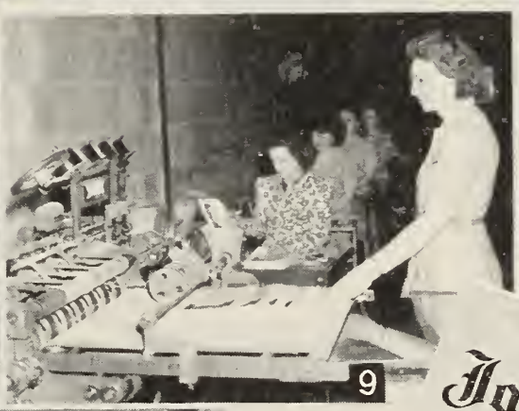

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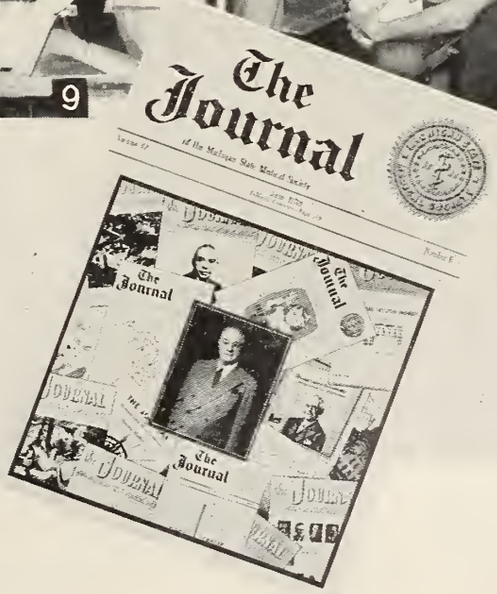



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The Journal
of the Michigan State Medical Society
The Journal
The Journal
The Journal

an attempt to translate to the members the ideals and objectives of the profession.

These ideals and objectives are high. Their standards, as dictated by the Council, shapes policy as regards editorial matter and advertising.

Under the latter heading, it is interesting to note that advertising lineage has jumped from 20⅞ pages in the January, 1933, issue, to an average of 53⅝ pages at the present time. Some state medical societies still refuse to allow inclusion of paid advertising. However, members of the Michigan State Medical Society, through their Council, decided some time ago that carefully screened advertising was distinctly worthwhile.

The advertising of local concerns are presented to our publication committee for acceptance or rejection. No product subject to review of the AMA Councils can be advertised in THE JOURNAL until Council acceptance is gained.

C M A B



The staff of the Cooperative Medical Advertising Bureau of the American Medical Association, Chicago, Illinois—from left to right, Harriet Lev, Lester A. Putzler, Eileen Murphy, D. Adelaide Kopp and Alfred J. Jackson, Director.

The Co-operative Medical Advertising Bureau—better known as the CMAB—of the American Medical Association, serves THE JOURNAL in securing a large volume of national advertising of reputable concerns. The Bureau not only sells the space, but gives a complete service in securing and reviewing copy, furnishing printing plates, in billing and collecting funds involved, and in transmitting revenue for all space cleared through its office.

Alfred J. Jackson, formerly with the advertising department of the AMA publications, assumed office as director of the CMAB, on January 1, 1946. For the JMSMS itself, L. Fernald Foster, M.D., is business manager; William J. Burns serves as advertising manager, and Harry Lipson is the local representative in the Detroit office.

And now, in 1948, we find 101 advertisers in the pages of THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY.

Production

The modernized JOURNAL—a far cry from the early issues—mounts up to 60,200 copies during the course of a year, requiring more than 22 tons of paper.

Perhaps you may be able to get a better picture of the production that goes into your publication if you will try to visualize the 288,000 sheets of paper (one year's editions) laid end to end to make a strip of paper 204 miles long.

The mechanical processes through which each month's edition of THE JOURNAL passes would hardly be recognized by the original editors, but, we are sure you will agree, the Bruce Publishing Company of Saint Paul, Minnesota, has mixed science and art to make this, your publication, a readable, artistic and informative organ. A special bouquet is due Miss Olive Seibert—the "contact man" of the publisher with the MSMS—who each month "puts THE JOURNAL to bed."

Back of this complex procedure, which continues day in and day out, month after month, that the record of Michigan's medical men may spread and endure, is the MSMS Publications Committee, composed of the following: Fred H. Drummond, M.D., Kawkawlin, chairman; Dean W. Myers, M.D., Ann Arbor; E. A. Oakes, M.D., Manistee; C. E. Umphrey, M.D., Detroit, and Wilfrid Haughey, M.D., Battle Creek.

These men, this publication, and the traditions of the Michigan State Medical Society had their humble beginnings in an obscure publication known as *The Michigan Journal of Homeopathy,* first published in Detroit on November 11, 1848—about the time gold was being discovered in California—by Drs. John Ellis and A. B. Thayer.

The publication died a few years later. The regular profession entered the field. Like the human race, it took many an attempt before a satisfactory product was evolved.

And, like the human race, the present JOURNAL is not perfection. It does attempt to maintain the high standards set by and for the protection of the membership of the Michigan State Medical Society, the advertisers and the medical profession. Criticisms and suggestions are always welcome.

MICHIGAN STATE MEDICAL SOCIETY

The 83rd Annual Session and Postgraduate Conference



O. O. Beck, M.D.
Birmingham
Council Chairman



P. L. Ledwidge, M.D.
Detroit
President



John S. DeTar, M.D.
Milan
Speaker



L. Fernald Foster, M.D.
Bay City
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, on September 20, 21, 22, 23, 24, 1948. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

P. L. Ledwidge, M.D.
President

O. O. Beck, M.D.
Council Chairman

J. S. DeTar, M.D.
Speaker

R. H. Baker, M.D.
Vice President

Attest:
L. Fernald Foster, M.D.
Secretary



R. H. Baker, M.D.
Pontiac
Vice Speaker

TWO-DAY SESSION OF HOUSE OF DELEGATES, SEPTEMBER 20-21, 1948

The 1948 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 20 at 10:00 a.m. The business of the House of Delegates will be transacted in the Book-Cadillac Hotel, Detroit.

The House also will meet Monday at 8:00 p.m. and on Tuesday, September 21 at 10:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

Seating of Delegates

"Any Delegates-Elect not present to be seated at the hour of call of the First Session may be replaced by an accredited alternate next on the list as certified by the Secretary of the County Medical Society involved."—MSMS By-Laws, Chapter 3, Section 3.

Michigan State Medical Society

Past Presidents 1866-1947

1866—*C. M. Stockwell, Port Huron
1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchcock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
1883—*A. F. Whelan, Hillsdale
1884—*Donald Maclean, Detroit
1885—*E. P. Christian, Wyandotte
1886—*Charles Shepard, Grand Rapids
1887—*T. A. McGraw, Detroit
1888—*S. S. French, Battle Creek
1889—*G. E. Frothingham, Detroit
1890—*L. W. Bliss, Saginaw
1891—*George E. Ranney, Lansing
1892—*Charles J. Lundy (died before taking office)
*Gilbert V. Chamberlain, Flint, Acting President
1893—*Eugene Boise, Grand Rapids
1894—*Henry O. Walker, Detroit
1895—*Victor C. Vaughan, Ann Arbor
1896—*Hugh McColl, Lapeer
1897—*Joseph B. Griswold, Grand Rapids
1898—*Ernest L. Shurly, Detroit
1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson
1903—*Wm. F. Breakey, Ann Arbor
1904—*B. D. Harison, Sault Ste. Marie
1905—*David Inglis, Detroit
1906—*Charles B. Stockwell, Port Huron
1907—*Hermon Ostrander, Kalamazoo
1908—*A. F. Lawbaugh, Calumet
1909—*J. H. Carstens, Detroit
1910—*C. B. Burr, Flint
1911—*D. Emmett Welsh, Grand Rapids
1912—*Wm. H. Sawyer, Hillsdale
1913—*Guy L. Kiefer, Detroit
1914—*Reuben Peterson, Ann Arbor
1915—*A. W. Hornbogen, Marquette
1916—*Andrew P. Biddle, Detroit
1917—*Andrew P. Biddle, Detroit
1918— Arthur M. Hume, Owosso
1919—*Charles H. Baker, Bay City
1920—*Angus McLean, Detroit
1921—*Wm. J. Kay, Lapeer
1922—*W. T. Dodge, Big Rapids
1923—*Guy L. Connor, Detroit
1924—*C. C. Clancy, Port Huron
1925—*Cyrenus G. Darling, Ann Arbor
1926— J. B. Jackson, Kalamazoo
1927— Herbert E. Randall, Flint
1928— Louis J. Hirschman, Detroit
1929— J. D. Brook, Grandville
1930—*Ray C. Stone, Battle Creek
1931—*Carl F. Moll, Flint
1932— J. Milton Robb, Detroit
1933—*George LeFevre, Muskegon
1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936— Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938— Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943— C. R. Keyport, Grayling
1944— A. S. Brunk, Detroit
1945— R. S. Morrish, Flint
1946— Wm. A. Hyland, Grand Rapids

*Deceased.

MICHIGAN STATE MEDICAL SOCIETY

The 83rd Annual Session and Postgraduate Conference

Book-Cadillac Hotel, Detroit, September 22, 23, 24, 1948

INFORMATION

DETROIT WILL BE HOST TO MSMS IN SEPTEMBER

The Program of the General Assembly for the 83rd Annual Session and Postgraduate Conference of the Michigan State Medical Society lists guest speakers from all parts of the United States and Canada. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated postgraduate course in all phases of medicine and surgery for the busy practitioners of Michigan and neighboring states and the Province of Ontario, on September 22, 23, 24, 1948.

Registration, Tuesday afternoon through Friday afternoon, September 21-24, Fifth Floor, Book-Cadillac Hotel, Detroit.

No registration fee for AMA and Canadian MA members.

Admission by badge only.

Postgraduate Credits given to every MSMS member who attends MSMS Annual Session.

Seven General Assemblies—Thirteen Section Meetings—Twenty-two Discussion Conferences on September 22, 23, 24.

Public Meeting. The Third General Assembly, Wednesday, September 22, 8:30 p.m.—Officers' Night—will be open to the public. Invite your patients and friends to hear an internationally famous personage scheduled for this program.

Papers will begin and end on time. This scientific meeting will feature by-the-clock promptness and regularity.

MSMS House of Delegates convenes Monday, September 20 at 10:00 a.m., Book-Cadillac Hotel, Detroit; it will hold two meetings on Monday, September 20, at 10:00 a.m. and at 8:00 p.m.; also two meetings on Tuesday September 21, at 10:00 a.m. and at 8:00 p.m.

Eighty-three Technical Exhibits will contain much of interest and value. Intermissions to view the exhibits have been arranged.

Please register at every booth.

Douglas Donald, M.D., Detroit, is General Chairman of the Detroit Committee on Arrangements for the 1948 MSMS Annual Session and Postgraduate Conference.

Press Relations Committee for the scientific session: H. F. Dibble, M.D., Detroit, Chairman; W. A. Chipman, M.D., Detroit; L. T. Henderson, M.D., Detroit; R. A. Johnson, M.D., Detroit; J. J. Lightbody, M.D., Detroit; C. J. Smyth, M.D., Detroit.

Transportation—The Pere Marquette Streamliners from Grand Rapids to Detroit afford a convenient means of transportation to the MSMS Annual Session for hundreds of physicians in the central and southeastern parts of the State.

The Medical Assistants Conference is scheduled for Thursday, September 23, in the English Room, Book-Cadillac Hotel, Detroit, beginning at 7:00 p.m. The Medical Assistants group is composed of doctors' office secretaries and nurses.

The Alumni of Loyola University School of Medicine will gather at a dinner meeting Thursday, September 23, at the Book-Cadillac Hotel.

The Woman's Auxiliary to the Michigan State Medical Society will present an attractive social and business program at the Fort Shelby Hotel, Detroit, to which the wife of every MSMS member is cordially invited.

Members of **Michigan Medical Service** will meet in annual session Monday, September 20, 2:00 p.m., in The Grand Ballroom, Book-Cadillac Hotel, Detroit.

WHAT IT TAKES TO BE A DOCTOR OF MEDICINE

1. Four Years of High School
2. Two Years of College (including Physics, Chemistry, and Biology)
3. Four Years in Medical College
4. One Year's Internship in a Hospital
5. A knowledge of the Human Body: Its Normal Structures, Functions and Governing Laws
6. A Knowledge of All Common Diseases in Order to Know What Disease is Present
7. A Knowledge of Effective Remedial Agents: Ability to Apply the One Most Needed.

These Minimum Essentials Should Be Possessed by All Who Treat the Sick

House of Delegates

ORDER OF BUSINESS*

MONDAY, SEPTEMBER 20

English Room, Book-Cadillac Hotel, Detroit

10:00 a.m.—First Meeting

1. Call to order by Speaker
2. Report of Committee on Credentials
3. Roll call
4. Appointment of Reference Committees
   (1) On Officers' Reports
   (2) On Reports of the Council
   (3) On Reports of Standing Committees
   (4) On Reports of Special Committees
   (5) On Amendments to Constitution and By-Laws
   (6) On Resolutions
   (7) On Special Memberships
5. Speaker's Address—J. S. DeTar, M.D., Milan
6. President's Address—P. L. Ledwidge, M.D., Detroit
7. President-Elect's Address—E. F. Sladek, M.D., Traverse City
8. Annual Report of the Council—O. O. Beck, M.D., Birmingham, Chairman
9. Report of Delegates to American Medical Association—L. G. Christian, M.D., Lansing, Chairman
10. Report of Commission on Health Care—R. L. Pino, M.D., Detroit, Chairman
11. Report of Special Committee on Revision of Constitution and By-Laws.—T. K. Gruber, M.D., Eloise, Chairman
12. Resolutions**
13. Reports of Standing Committees
    (a) Legislative Committee
    (b) Committee on Distribution of Medical Care
    (c) Medical Legal Committee
    (d) Preventive Medicine Committee
        Cancer
        Maternal Health
        Venereal Disease Control
        Tuberculosis Control
        Industrial Health
        Mental Hygiene
        Child Welfare
        Iodized Salt
        Heart and Degenerative Diseases
    (e) Committee on Postgraduate Medical Education
    (f) Committee on Public Relations (and sub-committees)
    (g) Committee on Ethics
14. Reports of Special Committees
    (a) Committee on Nurses' Training Schools
    (b) Scientific Radio Committee
    (c) Advisory Committee to Woman's Auxiliary
    (d) Scientific Work Committee (in Council's Report)
    (e) Beaumont Memorial Committee
    (f) State Interprofessional Committee
    (g) Rheumatic Fever Control Committee
    (h) Committee on State Veterans Affairs
    (i) Committee on Uniform Fee Schedule for Governmental Agencies
    (j) Committee on Rural Health
    (k) Committee on Michigan High School Athletic Accident Benefit Fund
    (l) Committee on National Emergency Medical Service
    (m) Committee on Red Cross Blood Bank

MONDAY, SEPTEMBER 20

Grand Ballroom, Book-Cadillac Hotel, Detroit

8:00 p.m.—Second Meeting

15. Supplementary Report of Committee on Credentials
16. Roll Call
17. Unfinished Business
18. New Business†
19. Reports of Reference Committees
    (a) On Officers Reports
    (b) On Reports of the Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Amendments to Constitution and By-Laws
    (f) On Resolutions
    (g) On Special Memberships

TUESDAY, SEPTEMBER 21

Grand Ballroom, Book-Cadillac Hotel, Detroit

10:00 a.m.—Third Meeting

20. Supplementary Report of Committee on Credentials
21. Roll call
22. Unfinished Business
23. New Business
24. Supplementary Reports of Reference Committees
    (a) On Officers Reports
    (b) On Reports of the Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Amendments to Constitution and By-Laws
    (f) On Resolutions
    (g) On Special Memberships

*See the Constitution, Article IV, and the By-Laws, Chapter 3 on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

†All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

TUESDAY, SEPTEMBER 21

Grand Ballroom, Book-Cadillac Hotel, Detroit

8:00 p.m.—Fourth Meeting

25. **Supplementary Report of Committee on Credentials**
26. **Roll Call**
27. **Unfinished Business**
28. **Supplementary Report of the Council**
29. **Supplementary Report of Reference Committees**
30. **Elections**
    (a) Councilors
        11th District—R. H. Holmes, M.D., Muskegon—Incumbent
        12th District—A. H. Miller, M.D., Gladstone, Incumbent
        13th District—W. H. Huron, M.D., Iron Mountain—Incumbent
    (b) Delegate to American Medical Association
        W. D. Barrett, M.D., Detroit—Incumbent
        T. K. Gruber, M.D., Eloise—Incumbent
        C. R. Keyport, M.D., Grayling—Incumbent
    (c) Alternate Delegates to American Medical Association
        R. L. Novy, M.D., Detroit—Incumbent
        R. H. Denham, M.D., Grand Rapids—Incumbent
        C. I. Owen, M.D., Detroit—Incumbent
    (d) President—Elect
    (e) Speaker of House of Delegates
    (f) Vice Speaker of House of Delegates

Adjournment

DELEGATES TO MSMS HOUSE OF DELEGATES, 1948

Names of Alternates appear in Italics

Officers
J. S. DeTar, M.D.
Milan, Speaker
R. H. Baker, M.D.
Pontiac, Vice Speaker
L. Fernald Foster, M.D.
Bay City, Secretary
W. A. Hyland, M.D.
Grand Rapids, Immediate Past President

Allegan
L. F. Brown, M.D., Otsego
E. B. Johnson, M.D., Allegan

Alpena-Alcona-Presque Isle
W. E. Nesbitt, M.D., Alpena
F. J. O'Donnell, M.D., Alpena

Barry
A. B. Gwinn, M.D., Hastings
C. A. E. Lund, M.D., Middleville

Bay-Arenac-Iosco
W. S. Stinson, M.D., 101 W. John, Bay City
A. D. Allen, M.D., 101 W. John, Bay City
A. H. Jacoby, M.D., 2202 Ninth, Bay City
N. R. Moore, M.D., 601 Fifth Ave., Bay City

Berrien
D. W. Thorup, M.D., Benton Harbor
J. G. Ruth, M.D., Benton Harbor

Branch
R. L. Wade, M.D., Coldwater
H. J. Meier, M.D., Coldwater

Calhoun
B. G. Holtom, M.D., 815 Security Bank Bldg., Battle Creek
G. W. Slagle, M.D., 1206 Security Tower, Battle Creek
C. G. Wencke, M.D., 1015 Security Bank Bldg., Battle Creek
H. C. Hansen, M.D., 417 Post Bldg., Battle Creek

Cass
S. L. Loupee, M.D., Dowagiac
J. H. Hickman, M.D., Dowagiac

Chippewa-Mackinac
B. T. Montgomery, M.D., Sault Ste. Marie
D. C. Howe, M.D., Sault Ste. Marie

Clinton
T. Y. Ho, M.D., St. Johns
G. E. Wahl, M.D., St. Johns

Delta-Schoolcraft
W. A. LeMire, M.D., Escanaba
A. H. Miller, M.D., Gladstone

Dickinson-Iron
D. R. Smith, M.D., Iron Mountain
L. E. Irvine, M.D., Iron River

Eaton
G. C. Stucky, M.D., Charlotte
P. H. Engle, M.D., Olivet

Genesee
A. H. Kretchmar, M.D., 608 First National Bldg., Flint
A. N. Thompson, M.D., Mott Foundation Bldg., Flint
A. C. Pfeifer, M.D., Mt. Morris
J. E. Livesay, M.D., 619 Mott Foundation Bldg., Flint
G. E. Anthony, M.D., 1015 Detroit, Flint
C. W. Stroup, M.D., 2002 E. Court, Flint
V. H. Morrissey, M.D., 101 Stockdale, Flint
F. W. Baske, M.D., 1217 Mott Foundation Bldg., Flint

Gogebic
A. C. Gorrilla, M.D., Ironwood
M. J. Lieberthal, M.D., Ironwood

Grand Traverse-Leelanau-Benzie
D. G. Pike, M.D., Traverse City
C. E. Lemen, M.D., Traverse City

Gratiot-Isabella-Clare
M. G. Becker, M.D., Edmore
E. S. Oldham, M.D., Breckenridge

Hillsdale
L. W. Day, M.D., Jonesville
O. G. MacFarland, M.D., North Adams

Houghton-Baraga-Keweenaw
T. P. Wickliffe, M.D., Calumet
A. M. Roche, M.D., Calumet

Huron
C. W. Oakes, M.D., Harbor Beach
W. B. Holdship, M.D., Ubly

Ingham
L. G. Christian, M.D., 108 E. St. Joseph, Lansing
H. W. Wiley, M.D., 300 W. Ottawa, Lansing
R. S. Breakey, M.D., 1211 Bank of Lansing Bldg., Lansing
John Wellman, M.D., 301 Seymour, Lansing
Milton Shaw, M.D., 320 Townsend, Lansing
J. S. Rozan, M.D., 511 Bank of Lansing Bldg., Lansing

Ionia-Montcalm
W. L. Bird, M.D., Greenville
E. S. Socha, M.D., Ionia

Jackson
J. J. O'Meara, M.D., Jackson
C. S. Clarke, M.D., Jackson
J. D. Van Schoick, M.D., Hanover
C. R. Dengler, M.D., Jackson

Kalamazoo
L. W. Gerstner, M.D., Kalamazoo
R. J. Armstrong, M.D., Kalamazoo
W. A. Scott, M.D., Kalamazoo
M. D. Verhage, M.D., Kalamazoo

Kent
W. B. Mitchell, M.D., Medical Arts Bldg., Grand Rapids
R. H. Denham, M.D., Metz Bldg., Grand Rapids
A. V. Wenger, M.D., 302 Lorraine Bldg., Grand Rapids
Andrew Van Solkema, M.D., 953 E. Fulton, Grand Rapids
L. C. Carpenter, M.D., Metz Bldg., Grand Rapids
G. W. DeBoer, M.D., 516 Medical Arts Bldg., Grand Rapids
Torrance Reed, M.D., Ashton Bldg., Grand Rapids
W. R. Torgerson, M.D., Metz Bldg., Grand Rapids
S. L. Moleski, M.D., 528 Medical Arts Bldg., Grand Rapids
C. E. Farber, M.D., 408 Metz Bldg., Grand Rapids
L. O. Grant, M.D., 420 Medical Arts Bldg., Grand Rapids
R. S. VanBree, M.D., 204 Lorraine Bldg., Grand Rapids

Lapeer
D. J. O'Brien, M.D., Lapeer
H. M. Best, M.D., Lapeer

Lenawee
P. L. Miller, M.D., Adrian
W. H. Hewes, M.D., Adrian

Livingston
H. G. Huntington, M.D., Howell
R. W. Lieber, M.D., Howell

Luce
F. R. Koss, M.D., Newberry
E. H. Campbell, M.D., Newberry

Macomb
D. B. Wiley, M.D., 4692 Van Dyke, Utica
E. G. Siegfried, M.D., New Haven

Manistee
E. B. Miller, M.D., Manistee
J. F. Konopa, M.D., Manistee

Marquette-Alger
R. A. Burke, M.D., Negaunee
L. W. Howe, M.D., Marquette

Mason
N. M. Comodo, Ludington

Mecosta-Osceola-Lake
T. B. Treynor, M.D., Big Rapids
P. B. Kilmer, M.D., Reed City

Medical Society of North Central Counties
(Otsego—Montmorency—Crawford—Oscoda—Roscommon—Ogemaw)
R. C. Peckham, M.D., Gaylord
C. G. Clippert, M.D., Grayling

Menominee
W. S. Jones, M.D., Menominee

Midland
R. S. Ballmer, M.D., Midland
H. L. Gordon, M.D., Midland

Monroe
T. A. McDonald, M.D., Monroe
J. P. Flanders, M.D., Monroe

Muskegon
L. E. Holly, M.D., 876 N. Second, Muskegon
T. J. Kane, M.D., 179 Strong Ave., Muskegon
Louis Le Fevre, M.D., 450 W. Western, Muskegon
R. D. Risk, M.D., 1160 Ransom, Muskegon

Newaygo
B. L. Masters, M.D., Fremont
T. R. Deur, M.D., Grant

Northern Michigan
(Antrim—Charlevoix—Emmet—Cheboygan)
J. R. Rodger, M.D., Bellaire
G. B. Saltonstall, M.D., Charlevoix

Oakland
H. A. Furlong, M.D., 932 Riker Bldg., Pontiac
C. R. Gatley, M.D., 97 N. Perry, Pontiac
T. H. Pauli, M.D., 206 Riker Bldg., Pontiac
F. J. Kemp, M.D., 1115 Peoples State Bank Bldg., Pontiac
J. M. Markley, M.D., 1026 Riker Bldg., Pontiac

Oceana
W. G. Robinson, M.D., Hart

Ontonagon
W. F. Strong, M.D., Ontonagon
H. B. Hogue, M.D., Ewen

Ottawa
D. C. Bloemendaal, M.D., Zeeland
K. N. Wells, M.D., Spring Lake

Saginaw
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L. C. Harvie, M.D., 405 Wiechmann Bldg., Saginaw
H. G. Kleekamp, M.D., 1005 Gratiot Ave., Saginaw
Stuart Yntema, M.D., 333 S. Jefferson, Saginaw

Sanilac
R. K. Hart, M.D., Croswell
N. J. Ellis, M.D., Croswell

Shiawassee
C. L. Weston, M.D., Owosso
J. F. Sahlmark, M.D., Owosso

St. Clair
George Waters, M.D., Port Huron
W. H. Boughner, M.D., Algonac

St. Joseph
R. A. Springer, M.D., Centerville
R. J. Fortner, M.D., Three Rivers

Tuscola
L. L. Savage, M.D., Caro
F. J. Gugino, M.D., Reese

Van Buren
W. R. Young, M.D., Lawton
E. H. Terwilliger, M.D., South Haven

Washtenaw
H. H. Riecker, M.D., St. Joseph Mercy Hospital, Ann Arbor
B. M. Harris, M.D., 220 Pearl, Ypsilanti
P. S. Barker, M.D., University Hospital, Ann Arbor
O. K. Engelke, M.D., 720 E. Catherine, Ann Arbor
R. W. Teed, M.D., 215 S. Main, Ann Arbor
A. M. Waldron, M.D., 324 S. State, Ann Arbor
R. I. Seime, M.D., 302 W. Cross, Ypsilanti
H. A. Miller, M.D., 300 E. Henry, Saline

Wayne
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J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
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W. J. Stapleton, Jr., M.D., 641 David Whitney Bldg., Detroit
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R. L. Novy, M.D., 858 Fisher Bldg., Detroit
Charles Kennedy, M.D., 10 Peterboro, Detroit
W. D. Barrett, M.D., 311 David Whitney Bldg., Detroit
T. K. Gruber, M.D., Wayne County General Hospital, Eloise
William Bromme, M.D., 318 Professional Bldg,, Detroit
Richard McKean, M.D., 1515 David Whitney Bldg., Detroit

C. J. Barone, M.D., 51 Eason, Highland Park
D. C. Beaver, M.D., Woman's Hospital, Detroit
E. H. Fenton, M.D., 15125 Grand River, Detroit
L. T. Henderson, M.D., 13038 E. Jefferson, Detroit
W. W. Babcock, M.D., 686 Fisher Bldg., Detroit
W. J. Cassidy, M.D., 1737 David Whitney Bldg., Detroit
E. G. Krieg, M.D., 1842 David Whitney Bldg., Detroit
E. A. Osius, M.D., 901 David Whitney Bldg., Detroit
W. S. Reveno, M.D., 968 Fisher Bldg., Detroit
C. I. Owen, M.D., Grace Hospital, Detroit
M. A. Darling, M.D., 673 Fisher Bldg., Detroit
H. J. Kullman, M.D., Veterans' Administration Hospital, Dearborn
A. E. Catherwood, M.D., 1337 David Whitney Bldg.,
S. W. Insley, M.D., 1202 Maccabees Bldg., Detroit
R. H. Pino, M.D., David Whitney Bldg., Detroit
L. W. Hull, M.D., 1701 David Whitney Bldg., Detroit
E. D. King, M.D., 5455 W. Vernor Highway, Detroit
B. H. Douglas, M.D., 334 Bates, Detroit
C. K. Hasley, M.D., 1429 David Whitney Bldg., Detroit
L. J. Bailey, M.D., 501 Professional Bldg., Detroit
L. J. Morand, M.D., 641 David Whitney Bldg., Detroit
H. F. Raynor, M.D., 1340 Maccabees Bldg., Detroit
J. E. Webster, M.D., 840 David Whitney Bldg., Detroit
A. V. Forrester, M.D., 18950 Woodward, Detroit
W. F. Seeley, M.D., 1807 David Whitney Bldg., Detroit
F. G. Buesser, M.D., 1515 Devid Whitney Bldg., Detroit
C. E. Lemmon, M.D., 1337 David Whitney Bldg., Detroit
H. B. Fenech, M.D., 324 Professional Bldg., Detroit
H. L. Morris, M.D., 1069 Fisher Bldg., Detroit
R. J. Schneck, M.D., 641 David Whitney Bldg., Detroit
R. A. Johnson, M.D., 7815 E. Jefferson, Detroit
L. J. Gariepy, M.D., 16401 Grand River, Detroit
M. H. Miller, M.D., 8120 W. McNichols Rd., Detroit
D. C. Somers, M.D., 760 Fisher Bldg., Detroit
R. Q. DeTomasi, M.D., 2642 Arndt, Detroit
W. L. Brosius, M.D., 2342 Leslie, Detroit
E. F. Dittmer, M.D., 14320 E. Jefferson, Detroit
R. V. Walker, M.D., 1255 David Whitney Bldg., Detroit
J. A. Kasper, M.D., Herman Kiefer Hospital, Detroit
L. A. Pratt, M.D., 2206 David Broderick Tower, Detroit
L. S. Fallis, M.D., Henry Ford Hospital, Detroit
P. J. Waltz, M.D., 16127 Woodward Ave., Detroit
R. C. Connelly, M.D., 1709 David Whitney Bldg., Detroit
H. L. Stern, M.D., 15826 James Couzens Highway, Detroit
E. C. Long, M.D., 2626 Rochester, Detroit
E. H. Lauppe, M.D., 1650 David Whitney Bldg., Detroit
S. M. Gillespie, M.D., 1101 Haigh, Detroit
J. E. Croushore, M.D., 573 Fisher Bldg., Detroit
C. F. Brunk, M.D., 7815 E. Jefferson, Detroit
D. I. Sugar, M.D., 1108 Stroh Bldg., Detroit
H. L. Clark, M.D., 634 Maccabees Bldg., Detroit
M. M. Frazer, M.D., 812 Kales Bldg., Detroit
L. J. Gravelle, M.D., 1101 David Whitney Bldg., Detroit
W. G. Reid, M.D., 974 Fisher Bldg., Detroit
D. H. Kaump, M.D., Providence Hospital, Detroit
J. K. Bell, M.D., 1654 First National Bldg., Detroit
G. C. Thosteson, M.D., 1139 David Whitney Bldg., Detroit
C. S. Ratigan, M.D., 22276 Garrison, Detroit
R. H. Bookmyer, M.D., 17198 Oak Dr., Detroit
L. B. Young, M.D., 857 Fisher Bldg., Detroit
C. R. Defever, M.D., 15124 Kircheval, Detroit
E. D. Rothman, M.D., 722 Maccabees Bldg., Detroit
C. E. Simpson, M.D., 1210 Kales Bldg., Detroit
T. G. Amos, M.D., 201 Curtis Bldg., Detroit
V. N. Butler, M.D., 28 W. Adams, Detroit
J. A. Witter, M.D., 344 Glendale, Detroit
A. E. Schiller, M.D., 2008 David Broderick Tower, Detroit

Wexford-Missaukee
L. E. Showalter, M.D., 400 E. Cass, Cadillac
C. E. Merritt, M.D., Manton

REFERENCE COMMITTEES, HOUSE OF DELEGATES, 1948

(All meetings of Reference Committees will be held in the Book-Cadillac Hotel, Detroit)

Credentials Committee

J. J. O'Meara, M.D., Jackson, *Chairman*
L. J. Bailey, M.D., Detroit — W. B. Harm, M.D., Detroit

Officers Reports
Parlor F

D. R. Smith, M.D., Iron Mountain, *Chairman*
R. J. Armstrong, M.D., Kalamazoo — A. H. Kretchmar, M.D., Flint
C. W. Oakes, M.D., Harbor Beach — C. L. Candler, M.D., Detroit
W. W. Babcock, M. D., Detroit — L. L. Savage, M.D., Caro

Reports of The Council
Parlor F

C. L. Weston, M.D., Owosso, *Chairman*
R. S. Ballmer, M.D., Midland — J. R. Rodger, M.D., Bellaire
E. A. Osius, M.D., Detroit — J. E. Webster, M.D., Detroit
C. I. Owen, M.D., Detroit — A. V. Wenger, M.D., Grand Rapids

Reports of Standing Committees
Parlor G

E. G. Kreig, M.D., Detroit, *Chairman*
O. K. Engelke, M.D., Ann Arbor — F. R. Koss, M.D., Newberry
L. T. Henderson, M.D., Detroit — A. N. Thompson, M.D., Flint
W. S. Jones, M.D., Menominee — F. A. Weiser, M.D., Detroit

Reports of Special Committees
Parlor G

G. C. Stucky, M.D., Charlotte, *Chairman*
D. C. Beaver, M.D., Detroit — B. T. Montgomery, M.D., Sault Ste. Marie
R. H. Denham, M.D., Grand Rapids — L. W. Hull, M.D., Detroit
L. W. Gerstner, M.D., Kalamazoo — W. S. Stinson, M.D., Bay City

Press Relations Committee
Parlor H

H. F. Dibble, M.D., Detroit, *Chairman*
R. H. Baker, M.D., Pontiac — Douglas Donald, M.D., Detroit
L. Fernald Foster, M.D., Bay City

Amendments to Constitution and By-Laws
Parlor I

E. D. Spalding, M.D., Detroit, *Chairman*
L. W. Day, M.D., Jonesville — L. E. Holly, M.D., Muskegon
H. A. Furlong, M.D., Pontiac — W. S. Reveno, M.D., Detroit
T. K. Gruber, M.D., Eloise — W. F. Strong, M.D., Ontonagon

Resolutions
Parlor J

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E. H. Fenton, M.D., Detroit — G. T. McKean, M.D., Detroit
B. M. Harris, M.D., Ypsilanti — W. E. Nesbitt, M.D., Alpena

Special Memberships
Parlor K

J. J. Lightbody, M.D., Detroit, *Chairman*
L. C. Harvie, M.D., Saginaw — E. C. Texter, M.D., Detroit
J. E. Livesay, M.D., Flint — D. B. Wiley, M.D., Utica

MSMS STENOGRAPHERS' ROOM
Suite 500

GENERAL ASSEMBLIES

All General Assemblies will be held in the Grand Ballroom of the Book-Cadillac Hotel, Detroit.

First General Assembly

WEDNESDAY, SEPTEMBER 22 *(morning)*

A.M.

9:00 *F. H. Lahey, M.D., Boston*
Director of Lahey Clinic; Surgeon-in-Chief to the New England Baptist Hospital and the New England Deaconess Hospital
"Present Status of Treatment of Thyroid Disease"
Dermatologist

9:30 *I. S. Wright, M.D., New York City*
Associate Professor of Clinical Medicine Cornell University Medical College; Chief of the Vascular Section of the Department of Medicine, Cornell University Medical College and New York Hospital; Civilian Consultant in Medicine to the Surgeon General—U. S. Army
"The Modern Treatment for Myocardial Infarctions Including the Use of Anticoagulants"



Looking for a Diagnosis?

Save time and effort—spare yourself a frantic search for the diagnosis of an unusual case . . . . . .

Attend your MSMS Annual Session;
Learn the Easy Way

11:00 *S. C. Cullen, M.D., Iowa City, Iowa*
Associate Professor of Surgery, Chairman Division of Anesthesiology, The State University of Iowa.
"The Rational Application of Sedative Drugs"

11:30 *A. R. Woodburne, M.D., Denver, Colorado*
Dermatologist
"Radiation Effects on the Skin and Their Treatment"

Second General Assembly

WEDNESDAY, SEPTEMBER 22 *(afternoon)*

P.M.

1:30 *A. L. Gesell, M.D., New Haven, Connecticut*
Director of the Clinic of Child Development, Yale University; Professor of Child Hygiene, Yale School of Medicine; Attending Physician at New Haven Hospital
"The Periodic Diagnosis of Infant Development. Its Significance in a Preventive Program of Clinical Supervision both for normal and handicapped children."

2:00 *J. E. Dees, M.D., Durham, N. C.*
Assistant Professor of Urology, Duke University Medical School
"Urological Aspects of Abdominal Pain"

2:30 *M. E. Davis, M.D., Chicago*
Joseph Bolivar De Lee, M.D., Chicago
Professor of Obstetrics and Gynecology, University of Chicago and Chicago Lying-in Hospital
"The Management of the Placental Stage in the Prevention of Postpartum Hemorrhage"

4:00 *Philip Thorek, M.D., Chicago*
Assistant Clinical Professor of Surgery, University of Illinois College of Medicine; Associate Professor, Cook County Graduate School of Medicine; Associate Attending Surgeon, Cook County Hospital; Attending Surgeon, Alexian Brothers' Hospital and American Hospital; Diplomate of the American Board of Surgery; Fellow of the American College of Surgeons.
"Acute Abdominal Emergencies."

4:30 *Waltman Walters, M.D., Rochester, Minnesota*
Professor of Surgery, Mayo Foundation; Head of Section in Surgery, Mayo Clinic.
"Present Status of the Treatment of Peptic Ulcer."

Third General Assembly

WEDNESDAY, SEPTEMBER 22 *(evening)*

PUBLIC MEETING

P.M.

8:30 *Officers' Night*
Presidential Address and induction of new President
Biddle Oration

Fourth General Assembly

THURSDAY, SEPTEMBER 23 *(morning)*

A.M.

9:00 *R. W. TeLinde, M.D., Baltimore*
"Present Day Indications for Hysterectomy"

9:30 *T. C. Galloway, M.D., Evanston, Illinois*
Associate Professor of Otolaryngology, Northwestern University Medical School, Attending Otolaryngologist, Evanston Hospital, Attending Otolaryngologist, Cook County Hospital
"Secretional Respiratory Obstruction and Bulbar Poliomyelitis"

11:00 *R. L. J. Kennedy, M.D., Rochester, Minnesota*
B.S., M.B., M.S. in Pediatrics; Professor of Pediatrics, Mayo Foundation, University of Minnesota and Head of the Section on Pediatrics, Mayo Clinic.
"Significance of Blood in the Stools in Infants and Children"

11:30 *Haven Emerson, M.D., New York City*
Member of Board of Health of the City of New York; Emeritus Professor of Public Health Practice, Columbia University; Visiting Lecturer in Public Health, University of Michigan.
"The Application of Preventive Medicine Through Local Government"

Fifth General Assembly

THURSDAY, SEPTEMBER 23 *(afternoon)*

P.M.

1:30 *J. B. Barnwell, M.D., Washington, D. C.*
Chief, Tuberculosis Division, Veterans Administration
"Results of a co-operative study on the effects of Streptomycin"

2:00 *L. R. Dragstedt, M.D., Chicago*
Professor of Surgery and Chairman of Department of Surgery at University of Chicago and Attending Surgeon at Albert Merritt Billings Hospital
"Gastric Vagotomy in the Treatment of Peptic Ulcer"

2:30 *F. H. Adler, M.D., Philadelphia*
Professor of Ophthalmology, University of Pennsylvania; Consulting Surgeon at Wills Hospital; Member American Ophthalmological Society and American Academy of Ophthalmology and Otolaryngology
"Thyrotropic Exophthalmos from the Viewpoint of the Ophthalmologist"

4:00 *E. G. Waters, M.D., Jersey City, N. J.*
Division Chief of Obstetrics at Margaret Hague Maternity Hospital, Assistant Professor of Clinical Obstetrics and Gynecology, Columbia University
"Labor Experiences of Elderly Primigravida" (Based upon 56,392 deliveries)

4:30 *R. R. Linton, M.D., Brookline, Mass.*
"Postoperative Thrombophlebitis"

State Society Night

THURSDAY, SEPTEMBER 23 *(evening)*

P.M.

10:00 Dancing for MSMS members and their ladies. Grand Ballroom, Book-Cadillac Hotel, Detroit

Sixth General Assembly

FRIDAY, SEPTEMBER 24 *(morning)*

A.M.

9:00 *T. G. Randolph, M.D., Chicago*
Instructor in Department of Internal Medicine, Northwestern University Medical School
"How Do You Know Your Patient is Food Sensitive?"

9:30 *D. M. Pillsbury, M.D., Philadelphia*
Professor, Department of Dermatology and Syphilology, University Hospital, University of Pennsylvania
"The Treatment of Syphilis"

11:00 *W. J. Reich, M.D., Chicago*
Attending Gynecologist at Fantus Clinics of Cook County Hospital; Professor, Gynecology, Cook County Graduate School; Attending Gynecologist at Fox River T.B. Sanitarium; Consulting Gynecologist, Hazelcrest General Hospital
"Practical Office Procedure in Gynecology"

11:30 *C. C. Burlingame, M.D., Hartford, Connecticut*
Psychiatrist-in-Chief of the Institute of Living (Neuro-Psychiatric Institute of the Hartford Retreat); Associate in Psychiatry of Columbia University; Editor "Digest of Neurology and Psychiatry"
"Good Psychiatry is Good Medicine"

Seventh General Assembly

FRIDAY, SEPTEMBER 24 *(afternoon)*

P.M.

1:30 *Alexander Brunschwig, M.D., New York City*
Attending Surgeon, Memorial Hospital and Professor of Clinical Surgery, Cornell University Medical College
"Radical Surgery for Advanced Pelvic Cancer"

2:00 *M. D. Leigh, M.D., Vancouver, B.C., Canada*
Director Department of Anesthesiology, The Vancouver General Hospital
"Pediatric Anesthesiology"

2:30 *S. P. Reimann, M.D., Philadelphia*
Director of The Lankenau Hospital Research Institute, and the Institute for Cancer Research in Philadelphia; Associate Professor of Surgical Pathology, Graduate School of Medicine, University of Pennsylvania; Professor of Oncology, Hahnemann Medical College and Hospital
"Attempts at the Chemotherapy of Cancer"

4:00 *G. H. Pratt, M.D., New York City*
Assistant Clinical Professor of Surgery New York Postgraduate Medical School and College; Chief of Vascular Surgical Clinic, New York Postgraduate Hospital; Attending Surgeon, St. Clare's Hospital
"Recent Advances in the Surgical Treatment of Peripheral Arterial Disease"

4:30 *W. L. Palmer, M.D., Chicago*
Professor Medicine, University of Chicago
"Nervous Indigestion"

General Assemblies end at 5:00 p.m.

Have You Made Your

HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY

83rd Annual Session

Detroit, September 22, 23, 24, 1948

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to E. C. Texter, M.D., Chairman of Housing Committee, c/ 1005 Stroh Bldg., Detroit Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

E. C. Texter, M.D., Chairman of Housing Committee,
Michigan State Medical Society Annual Session,
c/o 1005 Stroh Bldg., Detroit, Michigan.

Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for .....persons

.....Twin Bedded Room(s) for .....persons

Arriving September .....hour.....A.M.....P.M.

Leaving September .....hour.....A.M.....P.M.

(Names and addresses of all applicants including person making reservation).

Name Address City State

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Date ..... Signature .....

Address ..... City.....

SECTION MEETINGS

Tentative Program

WEDNESDAY, SEPTEMBER 22
(12:00 noon to 1:30 p.m.)
(luncheon meetings)

1. **Dermatology**
   A. R. Woodburne, M.D., Denver, Colorado
   "Nodular Diseases of the Extremities"
2. **Anesthesia**
   S. C. Cullen, M.D., Iowa City, Iowa
   "Nitrous Oxide—Curare Anesthesia for Major Surgery"
3. **Urology**
   J. E. Dees, M.D., Durham, N. C.
   "Unexplained Renal Hematuria"
4. **Gynecology-Obstetrics**
   M. E. Davis, M.D., Chicago
   "Abdominal versus Vaginal Delivery"

THURSDAY, SEPTEMBER 23
(12:00 noon to 1:30 p.m.)
(luncheon meetings)

5. **Pediatrics**
   R. L. J. Kennedy, M.D., Rochester, Minnesota
   "Xanthomatosis—Christian-Schuller's Denasi—and Eosinophilic Granuloma"
6. **Surgery**
   R. R. Linton, M.D., Brookline, Mass.
   "Portal Hypertension—Treatment by Venous Shunts"
7. **Otolaryngology**
   T. C. Galloway, M.D., Evanston, Ill.
   "Anoxia and Secondary Effects of Respiratory Obstruction"
8. **Ophthalmology**
   F. H. Adler, M.D., Philadelphia
   "The Choice of Operation in Paralysis of the Ocular Muscles"
9. **Public Health and Preventive Medicine**
   Haven Emerson, M.D., New York City
   "Distinctions Between Personal and Administrative Medicine"

FRIDAY, SEPTEMBER 24
(12:00 noon to 1:30 p.m.)
(luncheon meetings)

10. **Pathology**
    S. P. Reimann, M.D., Philadelphia
    "Certain Facts of Experimental Embryology and their Relation to Pathological Anatomy"
11. **Medicine**
    H. J. Kullman, M.D., Dearborn
    Chief of Medical Service, Veterans Administration Hospital, Dearborn, Mich., and Assistant Professor of Clinical Medicine, Wayne University College of Medicine, Detroit, Mich.
    "Amebiasis and its Complications, Diagnosis and Treatment"
12. **General Practice**
    W. J. Reich, M.D., Chicago
    "The Evaluation of Post-Menopausal Bleeding"
13. **Nervous and Mental Diseases**
    C. C. Burlingame, M.D., Hartford, Conn.
    "The Physicians Role in Marital Maladjustment"

Proposed Amendments to the Constitution, MSMS

Presented to the MSMS House of Delegates on September 20, 1947

(These proposals will be presented to the MSMS House of Delegates in September, 1948, for final action)

ARTICLE I—NAME

Section 1. The name of the organization shall be the Michigan State Medical Society.

ARTICLE II—COMPONENTS

Section 1. This Society shall be made up of single County Medical Societies and Component County Medical Societies, now in affiliation with this Society or which may be hereafter organized and chartered by The Council of the Michigan Medical Society, provided that single County Medical Societies shall be a society of the physicians in one county; and provided further that Component County Societies shall be deemed to be an organization of the physicians of more than one county; and provided that when in the judgment of the House of Delegates it is deemed to be to the best interests of this Society, a charter may be granted to a society comprising the physicians of two or more counties. County Societies and Component County Societies hereafter in this Constitution and By-Laws will be called County Societies.

ARTICLE III—PURPOSE

Section 1. To bring into one organization the physicians of this State of Michigan, and through it and other state societies to form and maintain the American Medical Association.

Sec. 2. To maintain a program of educational service to the public on matters of health and hygiene.

Sec. 3. To encourage among members of the medical profession the interchange of views on all phases of medical advancement and to thus better equip each member of the profession to serve society and promote the public health.

Sec. 4. To maintain a program of scientific education for the members of the Society keyed to the constantly developing discoveries in the field of medicine; and to foster, encourage and co-ordinate postgraduate facilities for the medical profession as a whole.

Sec. 5. To disseminate advances in medical research among the profession generally by the issuance of scientific publications.

Sec. 6. To maintain and to advance the standards of medical practice in this state, both with respect to the highest concepts of ethics, and to the principles of scientific progress.

Sec. 7. To acquire and hold such real and personal property as may be necessary for the full and proper execution of the corporate purpose as detailed herein.

Sec. 8. To carry on such organization functions and activities as are deemed necessary to effectively accomplish the above purposes; provided, however, that the Socity shall engage in no activities that cannot be construed as relevant, incidental or necessary to its charitable, educational and scientific purposes.

ARTICLE IV—DIVISIONS

Section 1. This Society as a state unit of the American Medical Association, and as the state expression of the County Societies of Michigan shall have three major divisions.

1. The Society as a whole, as when it meets in general session.
2. The Scientific Assembly with its subordinate or related bodies.
3. The House of Delegates with its subordinate or related bodies.

ARTICLE V—MEMBERS

Section 1. This Society shall consist of active members, honorary members, associate members, retired members, members emeritus, and life members, elected in accordance with the By-Laws.

ARTICLE VI—THE SOCIETY AS A WHOLE

Section 1. The Society as a whole shall hold an annual meeting at such time and place and of such duration as the House of Delegates and The Council may determine. This power may be delegated to The Council by the House of Delegates.

ARTICLE VII—SCIENTIFIC ASSEMBLY

Section 1. The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine, its allied specialities and the problems of public health conservation.

ARTICLE VIII—HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Michigan State Medical Society and shall consist of Delegates elected by County Societies and Component County Societies.

ARTICLE IX—OFFICERS

Section 1. The officers of this Society shall be a President, a President-Elect, a Treasurer, a Secretary, an Editor, a Speaker and Vice Speaker of the House of Delegates, Councilors, Members of the House of Delegates of the American Medical Association, and Alternate Delegates to the House of Delegates of The American Medical Association.

ARTICLE X—THE COUNCIL

Section 1. The Council shall be the executive body of the Society. It shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and the House of Delegates between Annual Sessions.

Sec. 2. An Executive Committee of The Council shall consist of its Chairman, Vice Chairman, Chairman of the Finance Committee, Chairman of the County Societies' Committee, Chairman of Public Relations Committee, the President, the President-Elect, the Secretary and the Speaker of the House of Delegates.

ARTICLE XI—FUNDS AND EXPENSES

Section 1. Funds for meeting the expenses of the Society shall be raised by annual dues, special assessments and voluntary contributions.

Sec. 2. Annual membership dues and assessments shall be fixed by the House of Delegates.

ARTICLE XII—AMENDMENTS

Section 1. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published at least once during the year in The Journal of the Society, or sent officially to each County Society at least two months before the meeting at which final action is to be taken.

Sec. 2. This Constitution or any amendment thereto shall become effective immediately upon its adoption.

Proposed Amendments to the By-Laws, MSMS

Presented to the MSMS House of Delegates on September 23, 1947

(These proposals will be presented to the MSMS House of Delegates in September, 1948, for final action)

CHAPTER 1—MEMBERSHIP

Section 1. The charter of each County Society shall require that each of the provisions of the Constitution and By-Laws of this State Medical Society, together with each amendment to either thereof, hereafter adopted, in so far as the same is applicable, shall be an integral part of the Constitution and By-Laws of the County Society to which a charter is issued and shall in no way be inconsistent with the Constitution and By-Laws of the Michigan State Medical Society.

Sec. 2. The House of Delegates is empowered to revoke the charter of any County Society whenever it finds that such society has materially breached any of the provisions of the Constitution or By-Laws of the State Society or has failed to function within the expressed spirit and purpose of the State Society, to such extent that revocation of charter is compatible with the best interests of the State Society. Petition for the revocation of charter of any County Society may be filed with The Council by a Councilor of the district within which such society is located, or by any three members of the County or the State Society or by the President of the State Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such petition together with written notice of the time and place of hearing on the petition shall be served on the affected County Society not less than sixty (60) days before the date of such hearing. The affected County Society may within thirty (30) days after service upon it of copy of the petition file with The Council a written answer thereto. The Council shall afford the affected County Society a fair hearing of the matters complained of, a suitable opportunity to present its defense and to be represented by counsel. Written arguments may be filed on behalf of the affected County Society and on behalf of the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter. The Council shall make its decision based on the records, setting forth in writing its finding of facts, conclusions and reasons therefore. If two-thirds of The Council do not concur in the conclusion that the charter of the affected County Society shoud be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of The Council concur in the conclusion that the charter of the affected County Society should be revoked, the Chairman of The Council shall transmit to the House of Delegates a report, consisting of the decision of The Council with records annexed, and shall serve a copy thereof on the affected County Society. The House of Delegates shall at the next regular or special session thereof following the transmittal of such report, but not less than sixty (60) days thereafter, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to The Council for further hearing and report. The action of the House of Delegates on the report of The Council shall be the final decision with reference to the revocation of the charter of a County Society.

Sec. 3. Each member of a County Society who is not in arrears as to dues and assessments shall be privileged to attend each meeting and take part in all the proceedings and shall be eligible to any office within the gift of the Society except as otherwise provided.

Any member in arrears for dues in the amount for one year or more may regain membership either by paying up all back dues or by being again elected to membership, at the option of The County Society.

For the purpose of determining the dues for new members only, the fiscal year of the Michigan State Medical Society shall be divided into four three-month periods. New members shall pay adjusted annual dues and assessments for the unexpired quarterly periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the State Secretary and such benefits shall not cover any period prior to their becoming members in good standing.

Sec. 4. In addition to the qualifications specified in their respective Constitutions and By-Laws, County Societies shall exact as qualifications for membership and its continued tenure, the acceptance and adherence to the Principles of Medical Ethics of the American Medical Association in accordance with the interpretation thereof by the Judicial Council of the American Medical Association, and such other qualifications as may be provided by this Constitution and By-Laws.

Sec. 5. No member who is under sentence of suspension or expulsion from any County Society of this Society, or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Society.

Sec. 6. Transfer of membership from one County Society to another shall be effectuated in the following manner:

The member who wishes such transfer shall make application to the County Society which he wishes to join, stating his reason for desiring a transfer of membership, which must include the fact that either his residence or office location is in the jurisdictional territory of that society, and tendering payment of dues for the remainder of the current year, calculated to the nearest quarter.

The Secretary of the County Society to which application is made shall request certification of standing from the County Society in which membership is then held. Upon receiving such request, the Secretary of the latter society shall supply certification of good standing, provided the following requirements have been met:

1. All County Society dues and assessments have been paid for the calendar year in which application for transfer was made.
2. County Society dues shall have been paid to cover that portion of the year preceding application for transfer, the time being calculated to the nearest quarter.
3. A member being granted a transfer shall not be under suspension or facing charges of unethical conduct.
4. In case the County Society dues have been paid in full for the year, and certification of good standing is being issued, the Secretary of the County Society shall refund County Society dues represented by the unexpired portion of the year, calculated to the nearest quarter.
5. Upon receipt of certification of good standing, and favorable action by the County Society to which application has been made, the transfer of membership requested shall be in effect.

Sec. 7. Resignation for transfer of membership to another state society shall be effected in the following manner:

Any member in good standing, not facing charges of unethical conduct, whose State and County Society dues and assessments are not in arrears, and who has moved his home or office to another state, may tender his resignation, which shall be effective at the beginning of the next quarter. Such resignation shall be transmitted to the State Secretary, who shall give the departing member certification of good standing.

Provided the portion of the calendar year following such resignation is not less than one-quarter, the Secretaries of the State and County Societies shall refund any dues and assessments already paid for the remainder of the year, calculated to the nearest quarter.

Sec. 8. Only active members are eligible to Retired, Emeritus or Life Membership. Transfers shall be by election in the House of Delegates. Requests for transfer shall be accompanied by certification by the Secretary of the State Society, as to years of practice and years of membership in good standing. The County Society of such members shall make request for certification, in writing, to the Secretary of the State Society thirty days in advance of an Annual Session.

CHAPTER 2—MEMBERS

Section 1. *Active Members*—Active Members shall comprise all the active members of County Societies. To be eligible for active membership in any County Society, each person must be under license to practice medicine, surgery and midwifery by authority of the Michigan State Board of Registration in Medicine.

Sec. 2. *Honorary Members*—County Societies may elect as Honorary Members any persons distinguished for their services or attainments in medicine or the allied sciences, or other services of unusual value to organized medicine or the medical profession. Upon recommendation of a County Society, the House of Delegates may elect such persons as Honorary Members of the State Society. Honorary Members shall pay no dues to the State Society and shall be without right to vote or hold office in either County or State Society.

Sec. 3 *Associate Member*—County Societies may elect as Associate Member:

1. Any person not a member of the profession but engaged in scientific or professional pursuits whose principles and ethics are consonant with those of this Society.
2. An intern serving the first year in any approved hospital, an intern of longer standing, a resident physician in training, a teaching fellow not engaged in private practice, but not after five years from the receipt of first medical degree (M.D. or M.B.).
3. A commissioned medical officer of the United States Army, Navy, Public Health Service and Veterans Administration on duty in this state who is not engaged in private practice of medicine.
4. A physician not engaging in any phase of medical practice.
5. A physician, resident of the State of Michigan, for the period of time he is in active military service of the United States previous to his engaging in active practice.
6. An active member, by transfer, for the period of time he is temporarily out of active practice on account of protracted illness.

Upon recommendation of a County Society, the House of Delegates may elect such person as Associate Member of the State Society. An Associate Member shall not pay dues in the State Society, nor shall he have the right to vote or hold office in either County or State Society.

County Societies may require an Associate Member to pay certain local dues, out of which THE JOURNAL subscription is to be paid to the State Society and for which such Associate Member shall receive THE JOURNAL.

Sec. 4. *Retired Member*—A member who has maintained his membership in a County Society of the State Society for a period of ten or more years, and who is certified by the County Society as having retired from practice, may be transferred to the retired members' roster. He shall be entitled to receive the publication of the Society at such rates as The Council may, from time to time, determine. He shall not have the right to vote or to hold office.

Sec. 5. *Member Emeritus*—Any physician who has been in practice for fifty years, and who has maintained a membership in good standing for twenty-five years, may, upon application and recommendation of his County Society, become a Member Emeritus. A Member Emeritus shall be relieved from paying State Society dues. He shall be entitled to all the benefits and privileges of membership.

Sec. 6. *Non-Resident Member*—County Societies may elect and retain as a Non-Resident Member any physician residing and practicing outside of the county who is a member in good standing of his own County Society. A Non-Resident Member shall not have the right to vote or hold office.

Sec. 7. *Life Member*—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

CHAPTER 3—GENERAL MEETING

Section 1. During each Annual Session the Society shall hold one or more General Meetings. The number and time of these General Meetings to be determined by The Council with or without the recommendation of the House of Delegates. Each General Meeting shall be presided over by the President or in his absence by the President-Elect or the Chairman of The Council. This meeting shall be called "Officers' Night."

Sec. 2. The following shall be the order of business in the General Meeting at which the reports of the House of Delegates are received:

1. Call to Order
2. Announcements and reports of House of Delegates
3. Retired President's annual address
4. Induction into office of Incoming President
5. Introduced of newly elected officers
6. Special addresses
7. Resolutions and motions

Sec. 3. Each registered Member at an Annual Session shall have an equal right to participate in the deliberations of a General Session and each Active Member, Member Emeritus and Life Member so registered shall have the right to vote on pending questions before the General Meeting.

Sec. 4. The General Meeting or any section of the Scientific Assembly may recommend to the House of Delegates or to The Council the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and the public. Such investigations and reports shall not become official action or expression of the Society until approved by the House of Delegates or The Council.

CHAPTER 4—HOUSE OF DELEGATES

Section 1. *Composition*—The House of Delegates shall be composed of delegates elected by the County Societies. Each County Society shall be entitled to send to the House of Delegates each year one Delegate for each fifty members and one delegate for each additional major fraction thereof. Any County which holds a charter from this Society and has less than fifty members shall be entitled to send one Delegate if its annual report has been properly filed with the Secretary.

Sec. 2. Officers of this medical Society and members of The Council shall be ex-officio members of the House of Delegates, and, with the exception of the Speaker of the House of Delegates, shall be without power to vote in the House of Delegates. The Past-President shall be a member at large of the House of Delegates during the first year of Past-Presidency with right to vote and hold office. All Past-Presidents shall have the right to the floor in the House of Delegates accorded to a regular Delegate without the right to vote.

Sec. 3. The House of Delegates shall transact all of the business of the Society not otherwise specifically provided for; it shall adopt rules and regulations for its own government and for the administration of the affairs of the Society; it shall provide for the organization of Councilor Districts, and, it shall provide for a division of the work of the Scientific Assembly of the Society into appropriate sections, adding new or discontinuing old sections.

Sec. 4. The House of Delegates shall meet annually at the time and place of the meeting of the Society as a whole in General Session, and may hold such number of meetings as the House may determine or its business require, adjourning from day to day as may be necessary to complete its business and specifying its own time for the holding of its meetings.

Sec. 5. A Delegate must have been a qualified Member of the State Society for at least two years preceding election or a Member Emeritus of the Society for at least two years preceding election.

Sec. 6. A Delegate once seated shall remain a Delegate through the entire session and his place shall not be taken by any other Delegate or Alternate, provided that in case of emergency the House of Delegates may seat a duly accredited Alternate from his County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by an accredited Alternate next on the list as certified by the Secretary of the County Society involved.

Sec. 7. The officers of County Societies shall certify to the State Secretary the names of the Delegates and Alternates who shall represent them at any Annual or Special Meeting.

Sec. 8. A quorum of the House of Delegates shall be constituted from 40 per cent of the accredited Delegates, providing that a majority of such quorum shall not come from any one County Society.

Sec. 9. The Officers of the House of Delegates shall be a Speaker and Vice Speaker. The Secretary of the State Society, elected by The Council, shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Meeting. The Speaker of the House of Delegates shall be a member of The Council and of its Executive Committee with right to vote.

Sec. 10. (a) The House of Delegates is the legislative body of the Society, and shall have authority to adopt and institute such methods and measures as it may deem most sufficient for the upbuilding and establishing of the interest of the profession in Michigan.

(b) It shall concern itself and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws and public health.

(c) It shall be active in the education of the public in regard to medical research and scientific medicine.

(d) Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the regulations of that parent organization and as hereinafter provided.

The number of Alternate Delegates shall equal the number of Delegates to the American Medical Association. Delegates and Alternates shall hold office for two years.

At each annual election, candidates for Delegates and Alternates shall be nominated in number equal to or greater than the number to be elected. Election shall be by ballot. The required number of high candidates shall be declared elected.

In case of a tie vote between any number of high candidates the winner, or winners, shall be decided by drawing lots supervised by the Speaker of the House of Delegates, provided, however, that any candidate thus tied shall have the right to a decision by ballot if he requests same.

The number of Alternate Delegates shall equal the number of Delegates. They shall be elected in exactly the same manner after all Delegates have been elected.

Alternate Delegates shall have relative seniority according to the respective number of votes received by them, and such seniority shall be designated at the time of election. Alternate Delegates serving their second year shall hold seniority over those Alternate Delegates serving their first year in office; provided, however, that re-election as Alternate Delegate shall carry with it no additional seniority.

Any vacancies caused by failure or inability of Delegates to attend shall be assigned to Alternate Delegates in order of their seniority as defined in this section.

(e) It shall divide the state into Councilor Districts.

(f) It shall have the authority to appoint committees, standing or special, from among its members or the members of the Society. Such committees are to report to the House of Delegates and their members may participate in the debate upon their committees' report.

(g) It shall approve each memorial and resolution in the name of the Society before the same shall become effective. Provided, that in the interim, in the presence of necessity for prompt action The Council is empowered to act in behalf of the Society.

(h) It shall elect the Councilors upon the nomination of the Delegates of the Councilor District whose Councilor's term expires.

(i) The House of Delegates shall provide for the division of the scientific work of the Society into appropriate sections. It shall prescribe the rules governing the meetings of these sections and the election of officers.

(j) It shall present a summary of its proceedings at a General Meeting of the Society and publish its minutes in THE JOURNAL.

(k) It shall have the following reference committees appointed by the Speaker: Committees on—

1. Council Reports.
2. Officer Reports.
3. Reports of Standing Committees.
4. Resolutions.
5. Reports of Special Committees.
6. Miscellaneous Reports.

(l) No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

(m) The election of officers shall be held at the last meeting of the House of Delegates at the Annual Session. Each nomination shall be made from the floor of the House. The Speaker having declared the nominations for any office closed, shall appoint tellers. In the event of having only one nominee, the candidate may be elected by a *viva voce* vote. Members elected to office shall take office with the induction of the Incoming President.

(n) Each resolution introduced into the House shall be in triplicate and presented to the Secretary immediately after the Delegate has read the same and shall be referred to the proper reference committee by the Speaker before action thereon is taken.

(o) Robert's Rules of Order when not in conflict with this Constitution and By-Laws shall govern the parliamentary proceedings of the House of Delegates.

CHAPTER 5—OFFICERS

Section 1. Officers shall be installed at the General Meeting at which the reports of the House of Delegates are received. They shall serve until the next Annual Session, provided that Councilors shall serve for five Annual Sessions, and provided further that not more than four Councilor terms expire normally at any Annual Session; provided further that Delegates to the American Medical Association may serve for two Annual Sessions.

Sec. 2. Officers shall serve until their successors are elected and inducted into office.

Sec. 3. At the Annual Session of this Society, next following his election, the President-Elect shall be installed into and assume the office of the President immediately following the annual address of the Retiring

President. He shall serve until his successor takes office. The assumption of office shall occur in General Session of the Society as a whole at which the reports of the House of Delegates are received. If no General Meeting is held at the Annual Session, the induction into office of the Incoming President and the newly elected officers shall be in the last meeting of the Annual Session of the House of Delegates.

Sec. 4. The President shall preside at each General Meeting of the Society, and shall fill each vacancy in office and committee with the advice of The Council unless otherwise provided for; he shall appoint the members of each committee not otherwise provided for; he shall deliver the President's Address; he shall have a voice in the deliberations of the House of Delegates and he shall be an ex-officio member of The Council with right to vote.

Sec. 5. The President-Elect shall be a member of The Council ex-officio, and shall act for the President in his absence or disability. If the office of President shall become vacant, the President-Elect shall succeed to the Presidency. If the office of President shall again become vacant, the Council shall elect a President for the unexpired term.

Section. 6. The Treasurer shall be the custodian of all the invested funds and the securities of the Society. He shall be elected by The Council and be accountable through The Council to the Society. The Council shall cause an annual audit to be made of his accounts.

Sec. 7. The Secretary shall be an active member of the Michigan State Medical Society and shall be paid a salary to be determined by the Council. He shall be the recording officer of the House of Delegates, The Council, Scientific Assembly, and General Session. He shall also discharge the following duties:

1. Collect all annual membership dues and such other moneys as may be due to the Society; keep membership records and issue membership certificates.

2. He shall make all required reports to the American Medical Association.

3. He shall deposit all funds received in an approved depository and disburse upon order of The Council. The Council shall cause an annual audit of his accounts by a certified public accountant. He shall render a report to The Council reviewing the Society's activities and imparting recommendations for the advancement of the Society's interest at each meeting of The Council.

4. Under the direction of The Council and with the advice of the Editor, he shall be the business manager of THE JOURNAL.

5. He shall superintend all arrangements for the holding of each meeting in compliance with the Constitution and By-Laws and instruction of The Council.

6. He shall send out all official notices of meetings, committee appointments, certificates of election to office and special duties of committees.

7. He shall receive and transmit to the House of Delegates and to The Council each committee and officers' annual report.

8. He shall institute and correlate each new activity under the supervision of The Council, and shall work on County Society integration and furnish information to the public concerning health matters as directed by the President and The Council.

The Executive Secretary, not necessarily a physician or a member of the Michigan State Medical Society, shall be appointed by The Council annually and shall be remunerated by a salary which shall be fixed by The Council.

The Secretary shall, with the approval of The Council, assign to the Executive Secretary such of the above duties as he deems advisable.

Sec. 8. The Speaker shall preside at sessions of the House of Delegates. He shall, with the approval of the President, appoint all committees created by the House of Delegates, unless otherwise provided, and shall perform such duties as custom and parliamentary usage require. He shall have a right to vote only when his vote shall be the deciding vote. He shall be a member of The Council and of its Executive Committee with the power to vote.

Sec. 9. The Vice Speaker shall assume the Speaker's duties in the Speaker's absence and shall have the right to vote when assuming such duties.

CHAPTER 6—THE COUNCIL

Section 1. The Council is the Executive body of the Society. It shall determine its own time and place of meeting. It shall elect its own Chairman and Vice Chairman to serve one year. It shall elect to serve one year, its Chairman, Vice Chairman, Chairman of the Finance Committee, Chairman of the County Societies' Committee, and Chairman of the Publication Committee; these with the President, the President-Elect, the Secretary, and the Speaker of the House of Delegates shall constitute the Executive Committee of The Council.

Sec. 2. Each Councilor shall be the organizer, peacemaker and censor for his District. He shall visit each County Society in his District at least twice a year and keep in touch with the activities of the societies constituting his District. He shall make such reports as the Chairman of the Council shall request concerning the condition of the profession in that District.

Sec. 3. Upon written complaint of at least half of the Delegates of the Councilor District involved, presented to the House of Delegates, in regular or special session, stating that the Councilor of said District has been remiss in his duties as prescribed above, and has been notified a month previously of this proposed action, the Speaker of the House shall bring the matter before the meeting for consideration. On two-thirds' vote of the House of Delegates this office shall be declared vacant and a successor elected.

Sec. 4. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by his County Society, may appeal therefrom to The Council of the Michigan State Medical Society. Notice of appeal shall be in writing and set forth the specific reasons for such appeal. The notice shall be filed with said Council and a copy thereof served on the member's County Society. Unless such appeal is taken within thirty (30) days after service by registered mail, return receipt requested, of the copy of the order of discipline on the affected member, such order shall be final and effective. As soon as practicable after receiving copy of notice of appeal, the County Society shall forward to The Council a complete record of the case, which record shall consist of the petition, answer, testimony, order appealed from and all other pertinent writings and exhibits. The Council shall thereupon transmit such record together with the notice of appeal to the Committee on Ethics of the State Society for review. The Committee on Ethics shall promptly review the record and may request the County Society or the affected member to furnish such further proofs in writing as the Committee deems necessary for the proper and full review of the matter. Written arguments may be filed by the County Society and the affected member within such time as may be designated by the Committee on Ethics. The Committee on Ethics shall make its findings and recommendations in writing and report the same to the Council. The Council shall thereupon affirm, reverse or modify the order appealed from by written decision, a copy whereof shall be served on the County Society and the affected member. Unless, within sixty (60) days of the service upon him by registered mail of copy of such decision, the affected member takes an appeal to the Judicial Council of the American Medical Association, the decision of the Judicial Council shall be final and effective. Provided further that the County Society, aggrieved by the decision of The Council of the State Medical Society, may within sixty (60) days appeal to the Judicial Council of the American Medical Association.

Sec. 5. It shall make careful inquiry into the condition of the profession in each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such County Society as already exists and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians in the same locality and shall continue these efforts until every reputable physician of the state has been brought under the Society's influence.

Sec. 6. It shall upon application provide and issue charters to County Societies organized in conformity with this Constitution and By-Laws and revoke such charters when deemed necessary.

Sec. 7. The Council shall direct and control the publication of THE JOURNAL.

Sec. 8. The Council shall elect a Secretary, an Editor of THE JOURNAL and a Treasurer at its annual meeting in January of each year. They shall take office immediately and serve for a term of one year, or until their successor is elected and takes office.

Sec. 9. The funds of the Society shall be disbursed only by order or action of the Council.

Sec. 10. Invested funds of the Society shall be delivered to the custody of the Treasurer by the Secretary.

Sec. 11. The Secretary shall collect annual dues, assessments and moneys owing the Society, placing them in a depository approved by The Council. He shall disburse them only upon order of The Council. The Council shall cause an annual audit be made of the funds of the Society by a certified public accountant and shall require the Treasurer and Secretary to give a bond in an adequate amount, this bond to be paid for from the funds of the Society.

Sec. 12. The Chairman of the Council, subject to its approval, shall appoint an Auditing Committee of three members, designating one of the members as its chairman.

The Auditing Committee shall inspect all bills and claims against the Society, and no bill or claim shall be paid except upon voucher or draft having the approval of at least two of the three members of the Auditing Committee. Provided, however, that any bill or claim may be paid without the approval of any member of the Auditing Committee by a majority vote or written approval of a majority of all the members of the Executive Committtee.

Sec. 13. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

Sec. 14. The Council shall render an Annual Report to the House of Delegates.

Sec. 15. The following County Societies shall constitute the Councilor Districts of the state:

First District—Wayne.

Second District—Eaton, Hillsdale, Ingham, Jackson.

Third District—Branch, Calhoun, St. Joseph.

Fourth District—Allegan, Berrien, Cass, Kalamazoo, Van Buren.

Fifth District—Barry, Ionia-Montcalm, Kent, Ottawa.

Sixth District—Clinton, Genesee, Shiawassee.

Seventh District—Huron, Sanilac, Lapeer, St. Clair.

Eighth District—Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola.

Ninth District—Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (including Antrim, Charlevoix, Cheboygan and Emmet), Wexford (Missaukee, Wexford).

Tenth District—Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Gladwin, Kalkaska and Ogemaw combined).

Eleventh District—Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana.

Twelfth District—Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger.

Thirteenth District—Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon.

Fourteenth District—Lenawee, Livingston, Monroe, Washtenaw.

Fifteenth District—Macomb, Oakland.

Sixteenth District—Wayne.

CHAPTER 7—STANDING COMMITTEES

Section 1. The following standing committees shall be appointed by the President with the advice of The Council:

(a) Committee on Legislation.
(b) Committee on the Distribution of Medical Care.
(c) Joint Committee on Health Education.
(d) Medical Legal Committee.
(e) Committee on Preventive Medicine.
(f) Committee on Postgraduate Medical Education.
(g) Committee on Public Relations.
(h) Committee on Ethics.

Sec. 2. The Committee on Legislation shall consist of a Chairman, the President-Elect of the State Medical Society and the Chairman of The Council of the State Medical Society and members to be appointed by the President with the advice of The Council.

The Committee on Legislation shall utilize every organized influence of the profession for the promoting of such legislation as will be for the best interests of the public's health and that of scientific medicine. It shall work under the direction of the House of Delegates or of The Council when the House of Delegates is not in session. No bill or proposed law or amendment shall be delivered to any member of the Michigan State Legislature for introduction in the name of this Society or by any of its committees until such proposed legislation shall have been endorsed and approved by The Council.

It shall submit an annual report with recommendations to the House of Delegates.

Sec. 3. The Committee on the Distribution of Medical Care shall consist of five members appointed by the President with the advice of The Council.

This Committee shall collect, analyze and distribute information, and advise Medical and other groups or individuals concerning Medical Economic Problems in Michigan. It may appoint sub-committees and seek information and co-operation whenever such action, in its judgment, is necessary to public welfare. It shall act as a central clearing house for the activities of Committees on the Distribution of Medical Care of the various County Societies throughout the state.

Sec. 4. The Medical Legal Committee shall consist of five members appointed by the President with the advice of The Council.

The Committee shall co-operate with the Medical Legal Counsel of each County Society in advising members as to their rights and duties in the practice of their profession.

It shall furnish upon application by any official Medical Legal Counsel of a County Society or a Councilor information and advice pertaining to the rights and duties of physicians in the practice of their profession.

Sec. 5. The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the advice of The Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944 the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term.

Sec. 6. Committee on Preventive Medicine shall consist of the Chairmen of the following Committees:

Committee on Cancer Control,
Committee on Maternal Health,
Committee on Venereal Disease Control,
Committee on Tuberculosis Control,
Committee on Industrial Health,
Committee on Mental Hygiene,
Committee on Child Welfare,

(Continued on Page 664)

MILESTONES IN CARDIORESPIRATORY HISTORY



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OF CAPPADOCIA (1st Century A.D.)

First accurate description of asthma;
separated asthma from orthopnea.
"If heart be affected,
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In the treatment of bronchial asthma,
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or in those in whom epinephrine
is contraindicated
has been stressed repeatedly.

SEARLE AMINOPHYLLIN*

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*Searle Aminophyllin contains at least 80%
of anhydrous theophylline.

(Continued from Page 662)

Committee on Heart and Degenerative Diseases,
Committee on Radio,
Committee on Postgraduate Medical Education,
Representatives to the Joint Committee on Health Education,
Such other committees as may from time to time be appointed to study and develop programs dealing with specific diseases,
The State Health Commissioner.

The Chairman of the Preventive Medicine Committee shall be appointed by the President, together with the members of all special committees, with the advice of The Council.

The duty of this committee shall be to collect, analyze and distribute information on preventive medicine, and to advise medical and other groups or individuals concerning problems in preventive medicine and public health.

Sec. 7. The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the advice of The Council. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term.

The duty of this Committee shall be to supervise for the Michigan State Medical Society all present postgraduate medical training in the state and, with the approval of the Executive Committee of The Council, make any changes, additions or discontinuances of present programs and initiate such new programs as they deem advisable.

Sec. 8. The Committee on Public Relations shall be appointed by the President with the advice of The Council. It shall be the duty of this committee: (a) to integrate and publicize all approved plans and projects emanating from The Council, the Executive Committee, and other standing and special committees of the Michigan State Medical Society; (b) to consider all plans and projects, and make suggestions and recommendations for improving or changing such plans for integration and publicizing; (c) to develop further plans for better physician-public contacts.

Sec. 9. The Committee on Ethics shall consist of eight members appointed by the President with the advice of The Council, each member to serve for a four-year term, so staggered that two members are selected annually. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term.

The Committee shall render advisory opinions on questions of ethics submitted to it by The Council.

On request of The Council it shall conduct an investigation, under rules approved by The Council, concerning the ethical conduct of a designated member of this Society and report its findings to The Council.

CHAPTER 8—REFERENDUM

Section 1. At any General or Special Meeting of the Society as a whole in General Session, it may by a two-thirds vote order a general referendum upon any question pertinent to the purposes and objects of the Michigan State Medical Society, organized medicine or the health of the public, provided, however, that a quorum at such General or Special Meeting shall consist of 300 members of the Michigan State Medical Society who are in good standing.

Sec. 2. The House of Delegates, by a majority vote of its members, may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, provided 300 members of the Society, in good standing, are present to constitute a quorum; provided further that two-thirds majority of the members present at such meeting shall determine the question and make it binding.

CHAPTER 9—SEAL

Section 1. The Society shall have a common seal. The power to change or renew the seal shall rest with The Council.

CHAPTER 10—EMERGENCY

Section 1. When prompt speech and action are imperative, authority to speak and act in the name of the Society is invested in The Council with the consent of the President.

CHAPTER 11—ANNUAL DUES

Section 1. The Secretary of each County Society shall collect and forward the dues to the State Secretary on or before April first of each year.

Sec. 2. Any member in arrears after April first of each official year shall stand suspended until his name is properly recorded and his dues for the current year properly remitted.

Sec. 3. Any County Society which fails to make the reports required at least thirty days before the Annual Meeting of the State Society shall be held suspended and none of its members or Delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

Sec. 4. An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately following such duty.

CHAPTER 12—COUNTY SOCIETIES

Section 1. All County Societies now in affiliation with the State Society or those which may hereafter be originated in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws or with the Principles of Medical Ethics of the American Medical Association, will upon application to The Council receive a charter and become a component part of this Society.

Sec. 2. Only one County Society shall be chartered in any county.

Sec. 3. Each County Society shall be the judge of the qualifications of its own members; but, as such societies are the only portals to this Society and the American Medical Association, each reputable practitioner of medicine who meets the requirements specified in the By-Laws, Chapter 2, Section 1, shall be eligible to active membership.

(a) A County Society may expel, suspend or otherwise discipline any of its members in accordance with the provisions of its constitution and by-laws; provided, however, that any member against whom such action is taken shall be accorded the benefit of the following procedures:

(b) Efforts at conciliation and adjustment of differences shall precede formal complaint against a member sought to be disciplined.

(c) Complaints against a member must be in writing and referred to the Ethics Committee of the County Society and shall set forth with reasonable particularity matters complained of.

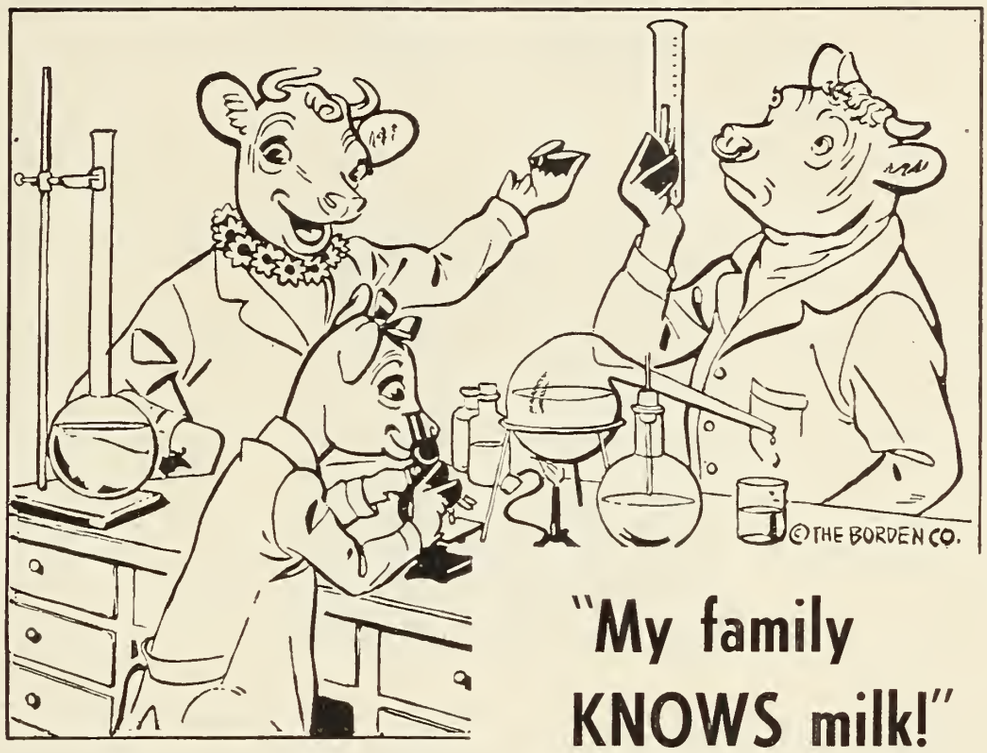
(d) A copy of the petition, together with notice of the time and place of hearing, shall be served on the affected member not less than thirty (30) days prior to the date of hearing.

(e) The affected member may file with his County Society written answer within fifteen (15) days after service upon him of a copy of such petition. He shall be accorded a fair hearing of the matters complained of before the Ethics Committee of his County Society and afforded an opportunity to present his defense, either in person or by counsel.

(f) A stenographic record shall be made of the proceedings at the hearing, and in case an appeal is taken by such member, a transcript thereof shall be prepared at the expense of the County Society for transmittal to the State Society. In such case, a copy of the transcript shall be furnished to the appellant as soon as may be.

(g) Any order of expulsion, suspension or other dis-

(Continued on Page 666)



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(Continued from Page 664)

cipline of a member shall be in writing, and shall set forth findings of fact, conclusions and reasons therefore. A copy of such order shall be served on the affected member as soon as may be.

(h) No such order shall become effective until the affected member has had an opportunity to avail himself of his rights of appeal as provided in these By-Laws.

(i) In County Societies having a Council, the procedure shall be: Written complaint, hearing before the Ethics Committee, a reference to The Council for adjudication, appeal to the Society as a whole, appeal to The Council of the State Medical Society and appeal to the Judicial Council of the American Medical Association.

(j) Each complaint, hearing or decision must give member at least thirty (30) days notice for rebuttal.

Sec. 4. A member of a County Society whose license has been revoked shall be dropped from membership automatically as of the date of revocation.

Sec. 5. A physician living near a county line may hold his membership in that County Society most convenient for him to attend, on permission of the Councilor or Councilors in whose jurisdiction he resides.

Sec. 6. Each County Society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, the moral and material conditions of every physician in the county; systematic effort shall be made by each member and by the County Society as a whole to increase the membership until it embraces every eligible physician in the county.

Sec. 7. At the Annual Meeting of each County Society or at a designated meeting of which ample notice has been given, each County Society shall elect Delegates or Alternate Delegates in conformity with the provisions of this Constitution and By-Laws to represent the County Society in the House of Delegates of this Society. The Secretary of the County Society shall immediately send a list of its Delegates to the Secretary of the State Society.

A Delegate, or in his absence the Alternate Delegate, becomes a member of the House of Delegates when properly registered and seated at the Annual Session following his election by the County Society. His membership in the House continues until the next Annual Session.

Sec. 8. The Secretary of each County Society shall keep a roster of its members and if practicable a list of non-affiliated physicians in the county, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this state, and such other information as may be deemed necessary.

Sec. 9. Each County Society shall appoint or elect a Committee on Legislation and Public Relations, and the County Secretary shall send the name and address of the Chairman to the Secretary of this Society.

CHAPTER 13—DEFINITION OF SESSION AND MEETING

Section 1. A session shall mean all meetings at any one call.

Sec. 2. A meeting shall mean each separate convention at any one session.

CHAPTER 14—AMENDMENTS

Section 1. These By-Laws may be amended by a majority vote of the Delegates seated, after the proposed amendment is laid on the table for one meeting. These By-Laws become effective immediately upon adoption.

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G. D. Cummings, M.D., Acting Commissioner

MICHIGAN DOGS SOURCE OF SALMONELLOSIS IN MAN

Michigan dogs are frequent hosts of Salmonella organisms and should be considered as a potential source of Salmonellosis in man. This is revealed in a study being conducted in the Laboratories of the Department.

In an article entitled "Salmonella from Dogs and the Possible Relationship to Salmonellosis in Man" in the March issue of the *American Journal of Public Health,* Arthur H. Wolff, D.V.M., Norman D. Henderson and Grace L. McCallum report that fifteen Salmonella types, most of which are pathogenic to man, have been recovered from stools of eighteen of the 100 dogs examined in their studies.

The types identified were: *S. manhattan, S. newport, S. minnesota* (both monophasic and diphasic varieties), *S. oranienburg, S. typhimurium, S. bredeney, S. worthington, S. give, S. cubana, S. cerro, S. kentucky, S. illinois* and *S. meleagridis.* There were two types isolated to which the antigenic formulae of XXVIII: y and III, XV:z^{10} respectively were ascribed.

The pathological significance of these isolations has not been entirely ascertained, according to the authors, and additional work is being performed toward that end.

WELL WATER CAUSES CYANOSIS IN INFANTS

High nitrate concentration in well water should be suspected as the cause of methemoglobinemia among Michigan infants particularly if the water used for the baby's formula and drinking is from a dug well of poor construction.

Analysis of nine samples of water from dug wells suspected in cases of methemoglobinemia in Michigan Department of Health Laboratories showed that each had a nitrate concentration of 200 to 900 parts per million. The level of safety is less than 10 parts per million. Survey of the suspected wells revealed that they were, in all cases, shallow dug wells, improperly located and improperly constructed.

Methemoglobinemia gives the baby a cyanotic appearance not unlike that of congenital heart disease but heart pulsation remains normal, and circulation and respiration are unaffected in early stages.

Methemoglobinemia occurs when in the intestinal tracts of certain infants nitrates are changed to nitrites which are absorbed into the blood changing the hemoglobin to methemoglobin. Methemoglobin is not toxic but is unable to carry oxygen. The blood becomes chocolate to dark brown in color and the skin takes on a bluish-grey cast.

The cyanosis is slowly progressive or may be recurrent. The baby has only digestive trouble such as chronic diarrhea or constipation, with or without abdominal pain.

Spontaneous transformation of the methemoglobin to hemoglobin usually results when the nitrate contaminated water supply is withdrawn, but the disease can be fatal. Treatment of advanced cases involves the use of methelene blue and Vitamin C.

The Michigan Department of Health laboratories will test for nitrate concentration, samples of any water suspected of causing methemoglobinemia, submitted by practicing physicians.

The Department in May began testing some municipal supplies for nitrate concentration.

VISITOR FROM NORWAY

Sverre Stene, Chemical Engineer of the Norwegian Institute of Public Health, who is in the United States for 100 days to catch up on sanitation information his country missed while "behind the curtain" was in the Department three days during April.

ANNIVERSARY OF GOITER BATTLE

The twenty-fourth anniversary of the sale of iodized salt for table use in Michigan occurred May 1. Sponsored by the Michigan State Medical Society and the Department of Health, and with the co-operation of salt manufacturers, the first salt treated to assist in preventing simple goiter among children was sold in the state in 1924.

REGRESS TO RAW MILK

Two Michigan cities, Ypsilanti and Manistique, have voted to permit sale of raw milk within their confines. A section of the 1947 Pasteurization Act makes it possible for a community to defeat the purpose of the Act through electing not to come under its provisions. Petitions signed by ten per cent of the voters of a municipality can compel the governing body to place the question on the ballot at the next general election.

TUBERCULOSIS LAWS

The Department has assisted the Michigan Tuberculosis Association in preparing a pamphlet which discusses the free treatment and hospital care available to tuberculosis patients of the state. Each tuberculosis patient in the state should have a copy of the pamphlet, "Who Pays for Hospital Care and Treatment." Copies are available from the Michigan Tuberculosis Association or the Department of Health. Copies of the revised tuberculosis law are also available from these sources.

DIAGNOSTIC SERVICE IN VD CENTER

The Michigan Rapid Treatment Center, which last year treated 658 cases of syphilis referred to it by practicing physicians of the state, this year is increasing its services.

Physicians may now refer private cases to the Center for diagnosis and for recommendations for treatment.

(Continued on Page 670)



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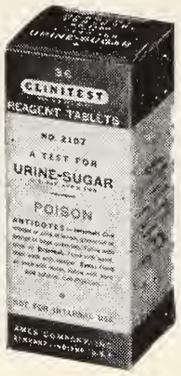
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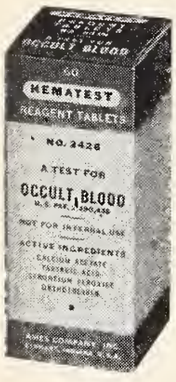
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DIAGNOSTIC SERVICE IN VD CENTER

(Continued from Page 668)

The patient will return to the private physician for any necessary treatment.

Where such services are desired the physician should send a letter with the patient to the Center stating that consultation service only is desired and that he intends to treat the patient.

The Center has bed space available so that private physicians may refer for treatment, cases in the following diagnostic categories:

1. Syphilis
   - Primary
   - Secondary
   - Early latent
   - Syphilis in pregnancy
   - Early congenital
   - Late asymptomatic
   - Neurosyphilis (Asymptomatic only)
2. Gonorrhea
   - Gonorrhea with complications
   - Treatment resistant gonorrhea
3. Chancroid
4. Granuloma Inguinale
5. Lymphogranuloma venereum

The length of stay at the Center required for treatment of syphilis patients is normally two weeks. Physicians should tell their prospective patients that they will be at the center for at least two weeks.

During recent months there has been considerable number of referrals of symptomatic neurospyhilis to the Center. It is not the policy of the Center to treat symptomatic neurosyphilis and it is requested that such cases not be sent to the facility. The danger of Herxheimer Reaction tends to create a considerable problem with this type of case in the Center.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*April, 1948*	*April, 1947*
Diphtheria	4	22
Gonorrhea	658	834
Lobar pneumonia	80	108
Measles	6484	343
Meningococcic meningitis	13	18
Pertussis	285	746
Poliomyelitis	6	5
Scarlet fever	604	511
Syphilis	973	1236
Tuberculosis	628	481
Typhoid fever	4	3
Undulant fever	24	25
Smallpox	0	0

RABIES SITUATION SERIOUS

Rabies in animals continues at approximately the same rate as last year. There were ninety-two positive heads in the first four months of this year compared with 103 positive heads for the same period last year. The total number for 1947 was 332.

The ninety-two positive heads were from seventeen counties and the City of Detroit. Seven counties had asked for dog quarantines by May 1; namely, Ottawa, Cass, St. Joseph, Washtenaw, Wayne, Livingston and Lapeer. Three counties had compulsory vaccination as a prerequisite for licensing. These were Berrien, Van Buren and Kalamazoo.

There was no evidence that rabies had infected Michigan foxes by May 1, but during 1947 Ohio reported eighty-five positive fox heads and Indiana reported two positive fox heads. If rabies is not controlled in Michi-

Say you saw it in the Journal of the Michigan State Medical Society

gan, there is no doubt but that wildlife will be ultimately involved.

MEASLES CONTINUE

Measles continued to be reported at approximately 1500 cases a week. During the week ending April 30, there were 1483 cases reported. This brought the number of cases reported this year to 22,717.

By and large, the outbreak had died out in the southwest area of the State by May 1 and was concentrated in the Detroit and Wayne County area.

Communication

Wilfrid Haughey, M.D., Editor
Journal Michigan State Medical Society
Battle Creek, Michigan

I am submitting a brief manuscript for publication in your Journal.† It is a new vista on cancer—development of an anti-cancer biotic. One reason for selecting this Journal is that when I was an eager intern at the University of Michigan you published the first scientific paper I ever wrote. The chief reason is that this may well be the first in a series of articles over the years, and if Michigan men, those in practice in the State plus the University of Michigan researchers, become the basic unit, it is suitable for your JOURNAL to publish the first paper.

The idea of using a Cancer Cemetery as a glorified petri dish and culture medium to develop and ascertain what molds can or be taught to lyse cancer cells, so that from them an anti-cancer penicillin can be made, needs the triangle of: (a) city and country doctors, (b) university research, (c) industrial manufacture. All are in Michigan.

Respectfully,

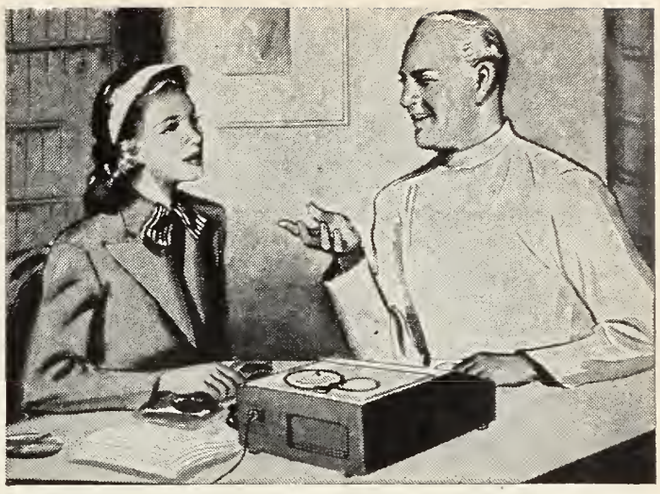
HAROLD S. HULBERT, M.D.
Editor, Journal of Criminal Law and Criminology

†See "A Cancer Cemetery," page 628.

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In Memoriam

MYRON WILLIAM CLIFT, M.D., Midland, Michigan. Born April 14, 1883, in Bay City, Michigan; graduated from the University of Michigan Medical School in 1905; well-known x-ray specialist. Dr. Clift served as associate professor of Roentgenology at the Detroit City College and as Consultant and Officer in charge of the Army X-Ray School in Paris, France, during World War I. He was the author of a number of articles on medical subjects appearing in medical literature, the most recent being that of "A New Nasopharyngeal Radium Applicator" for irradiation of the eustachian tube, which appeared in the September, 1944, issue of the *Archives of Otolaryngology*. He was a member of the Genesee County Medical Society, the American Medical Association and the Michigan State Medical Society; also the American Board of Radiology and the American College of Physicians. Dr. Clift died on May 7, 1948, in Midland, Michigan, at the age of sixty-five.

* * *

E. GLENN McPHERSON, M.D., Detroit, Michigan. Born in 1895 in Indiana; graduated from the Indiana University School of Medicine in 1920. Dr. McPherson was a specialist in industrial surgery. He was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. McPherson passed on in February, 1948, in Detroit, Michigan, at the age of fifty-one.

* * *

ADOLPH SHOENFIELD, M.D., Detroit, Michigan. Born in 1890 in Austria-Hungary; graduated from the Harvard Medical School in 1918. Dr. Shoenfield was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Shoenfield died on November 26, 1947, in Detroit, Michigan, at the age of fifty-seven.

* * *

ROBERT JAMES McCLURE, M.D., Calumet, Michigan. Born, 1908; graduated from University of Michigan Medical School, 1933. Dr. McClure was a specialist in ophthalmology, otology, laryngology and rhinology, a member of the Houghton County Medical Society, the American Medical Association and the Michigan State Medical Society. He was killed in the crash of a private plane at Larium, Michigan, on May 4, 1948, at the age of forty-one.

* * *

ERSON MILLS CUNNINGHAM, M.D., Cassopolis, Michigan. Born February 14, 1868 in Warrenton, Indiana; graduated from the University of Indiana in 1898. Further study was taken at the Rush Medical School in Chicago and Vanderbilt University. Dr. Cunningham was a life member and a past president of the Cass County Medical Society, a member of the American Medical Association and a former member of the Michigan State Medical Society. He was a specialist in ophthalmology, otology, laryngology and rhinology, and had been a practicing physician for fifty-seven years. Dr. Cunningham died of cerebral hemorrhage May 13, 1948 in Dowagiac, Michigan, at the age of eighty years.

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RED CROSS BLOOD PLASMA PROGRAM

(Continued from Page 642)

Similar blood bank centers may be organized later in other places if the need is established by the local medical society, and hospitals with the proper co-operation of the nearest American Red Cross Chapter.

The fact that the supply of war surplus plasma will probably be exhausted sometime in 1948, warrants a careful consideration of this new source of blood and blood products. The medical profession might well weigh the advisability of giving its support to such a program.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of April 21, 1948

• Monthly financial reports and bills payable were presented, studied and approved.

• $40,000 transferred from current Public Education Account and segregated in P. E. Reserves.

• Report made by Public Relations Counsel that MSMS has accomplished almost all of the instructions embodied in Resolutions adopted at the first Michigan Rural Health Conference.

• MSMS Secretary Foster authorized to make vigorous protest to Senators Vandenberg and Ferguson against designation of Doctors of Medicine as a special group for induction up to forty-five years of age, in preliminary prints of legislation yet to be introduced to reactivate Selective Service.

• Reports accepted from Chairman of MSMS Committee on National Emergency Medical Service concerning activities at AMA-E.M.S. Committee meeting, Chicago, April 5-6; from Legislative Committee; Child Welfare Committee; Maternal Health Committee's Advisory Committee on Therapeutic Abortions and Sterilization; Rheumatic Fever Control Committee; Permanent Conference Committee of MSMS-Michigan Hospital Association-Michigan Nurses Association from Special Committee on Basic Science Act administration; and from the Michigan Health Council's sub-committee on Program.

• Beaumont Memorial plans at Mackinac Island presented by W. F. Doyle, Vice Chairman of the Mackinac Island Park Commission.

• G. Don Cummings, M.D., Lansing, acting State Health Commissioner, discussed mutual problems and interests with the Executive Committee of The Council.

• Blue Cross vs. AMA coverage of its employes was thoroughly discussed and Editor Haughey was authorized to send a communication on this subject to MSMS membership via the Secretary's Letter. Proper contacts with the AMA authorities also authorized.

• Vote of thanks to H. H. Cummings, M.D., Ann Arbor and Grover C. Penberthy, M. D., Detroit on the success of the second Michigan Postgraduate Clinical Institute, was authorized; Dr. Cummings acted as Chairman and Dr. Penberthy as Vice Chairman.

• D. Bruce Wiley, M.D., Utica was re-elected as Michigan Chairman and MSMS representative to AMA Grass Roots Conference of June 20 in Chicago.

• Michigan's Delegates to AMA House of Delegates invited to attend May 19 Executive Committee meeting to discuss matters of national medical interest, prior to AMA session in Chicago, June, 1948.

• Liaison Committee with Michigan State Pharmaceutical Association appointed.

• Public Relations progress outlined by Mr. Brenneman, who was congratulated on his recent honor in being appointed Consultant in Public Relations by the State Bar of Michigan.

The United States Chapter, International College of Surgeons, will hold its 13th Assembly and Convocation in Kiel Auditorium, St. Louis, November 16-19, 1948.

* * *

The American College of Physicians will hold its Annual Session at the Waldorf Astoria Hotel, N. Y. the week of March 28, 1949.

* * *

Caesarian Sections.—The *Bulletin of the California Physicians Service* reports that California physicians are delivering 3,000 babies per year, of which 800 are caesarian sections.

* * *

Irving I. Edgar, M.D., Detroit psychiatrist, was elected a Fellow of the American College of Physicians, at the annual session held in San Francisco, California, April 21, 1948.

* * *

E. F. Sladek, M.D., Traverse City, President-Elect of the Michigan State Medical Society, addressed the Indiana State Medical Association on May 27 in Evansville. His subject was "The Modern Practice of Medicine."

Dr. Sladek also represented the Michigan State Medical Society at the Annual Session of the Illinois State Medical Society in Chicago the week of May 10.

* * *

E. I. Carr, M.D., Lansing and L. J. Gariepy, M.D., Detroit, attended the Sixth Assembly of the International College of Surgeons in Rome, Italy, the week of May 18. Dr. Gariepy is Secretary of the United States Chapter, I.C. of S., and Dr. Carr is Vice Regent for Michigan.

* * *

The Cover—Editor Wilfrid Haughey, M.D., Battle Creek, surrounded by recent covers of THE JOURNAL, MSMS. Under Dr. Haughey's progressive direction, JMSMS has attained a top position among state medical journals.

* * *

Members of the Kent County Medical Society were guests of the Pharmacy Association of Grand Rapids at

a baseball excursion to Detroit on June 17. The doctors travelled by charter bus to Detroit, inspected the Parke, Davis Laboratories, and spent the afternoon at Briggs Stadium (Tigers vs. Athletics).

* * *

Hugh W. Brenneman, MSMS Public Relations Counsel, spoke before the Van Buren County Medical Society on April 13, the South Haven Kiwanis Club on May 17, and the Optimist Club of Lansing on June 7. His subject in each instance covered the voluntary socio-economic activities of the medical profession designed to further the health of the people.

* * *

Orchid for the Michigan Postgraduate Clinical Institute: "Your recent Postgraduate Institute afforded me a most authoritative (and most hospitable and comfortable) way of keeping abreast of current clinical thoughts. I shall certainly hope to be present again next year if I am invited."—R. A. Kennedy, M.R.C.S., D.P.H., Medical Officer of Health, St. Thomas, Ontario.

* * *

Ben E. Goodrich, M.D. and T. D. Johnson, M.D., both of Detroit, were guest speakers at the Fourteenth Annual Meeting of the American College of Chest Physicians, Chicago, June 17-20, 1948. Their subject was "Chronic Bilateral Basal Pulmonary Fibrosis."

William Tuttle, M.D. and George L. Waldbott, M.D., also of Detroit, were Discussants of other papers on the program.

* * *

When the American people went to war in 1917 to "make the world safe for democracy" they signed an IOU for nearly $400-billion. World War I cost $24-billion; World War II is estimated as close to $244-billion. Additional lend-lease and "loans" will bring the total almost to the $400-billion mark. By counting $3.00 every second and keeping it up for a little over 4,000 years, you'll get an idea how much money $400 billion is!

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, addressed the Medical Society of Northern Michigan in Petoskey on April 4. His subject was "Public Relations in Medicine." On April 15 Dr. Foster spoke to the Town Club of Lansing on "Medicine and Bureaucracy" with over 300 persons present at this dinner meeting.

Dr. Foster addressed the Alpena County Medical Society on April 29 on "Rheumatic Fever." On May 13 his talk to the Adrian Rotary Club was entitled "Our National Health Problem."

* * *

Dr. Frederick F. Yonkman, Director of Research, Ciba Pharmaceutical Products, Inc., Summit, New Jersey, and Lecturer in Pharmacology and Therapeutics, Columbia University, College of Physicians and Surgeons, addressed the American Pharmaceutical Manufacturers' Association at their Pan-American meeting in Havana, Cuba, on April 14 on the topic "New Scientific-Medical Trends and Developments in the Pharmaceutical Industry." Dr. Yonkman also addressed the medical staff of the University of Havana on the subject "Influence of Sympatholoytic Drugs on Vascular Diseases."

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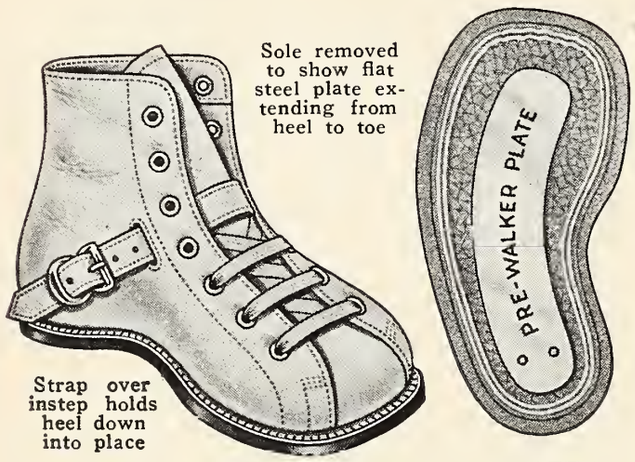
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Psychiatric Patients in Hospitals.—At the end of 1946, 529,247 persons, or *382.4 out of every 100,000* in the civilian population of the continental United States, were in hospitals for the prolonged care of psychiatric patients according to figures of the Mental Hygiene Division of the Public Health Service. The number of resident patients increased during the year by 10,575, representing about 2 per cent of the 518,672 present at the beginning of the year. The number of first admissions to prolonged care hospitals during 1946 was 153,025, or 110.6 per 100,000 of the estimated civilian population as of July 1, 1946.

* * *

T. E. DeGurse, M.D., Marine City, Michigan's Foremost Family Physician, was honored by the physicians of the Seventh Councilor District at a dinner meeting in Bad Axe on April 27. The honor guest has been longtime Councilor of the Seventh District. R. C. Dixon, M.D., of Pigeon, President of the Huron County Medical Society, acted as toastmaster and introduced P. L. Ledwidge, M.D., Detroit, President of the Michigan State Medical Society and MSMS Councilors W. E. Barstow, M.D., St. Louis and F. H. Drummond, M.D., Kawkawlin, each of whom spoke of the accomplishments of Dr. DeGurse during a long life of medical service to his community.

* * *

The Washtenaw County Medical Society authorized its President to appoint a Committee, to be known as the "Medical Service Committee" the duties of which are to receive the names of all physicians willing to accept off-hours calls, and to list them according to location (Ann Arbor area, Ypsilanti area), to supply said list periodically to the various hospitals in Washtenaw County, the County Health Department, the Nurses Bureau, and to all doctors of medicine in the county; the Committee will re-list its physicians in this category in September of every year; and finally, all complaints on medical service will be referred to the Medical Service Committee.

* * *

Michigan's census continues to climb in spite of the fact that there were less births during the first quarter of this year than there were in the same period of 1947.

Births, during the first quarter of 1948, exceeded by 20,716 the deaths during the same period, according to Department figures.

First quarter births numbering 35,214, exceeded by 5,994 the five-year average for the quarter, but fell 3,618 short of the record first quarter which was in 1947. The record quarter for births in the state was the final quarter of 1946 when 44,675 were reported.

Deaths for the first quarter of 1948 totalled 14,498. The five-year average was 14,425, and last year's first quarter figure was 14,585.

* * *

A. M. Hume, M.D., Owosso, was honored with a testimonial dinner by his community on Tuesday, May 4, 1948. The oldest living Past President of the Michigan State Medical Society (1918-1919) was acclaimed by Kenneth F. Crawford, Owosso's Mayor, G. W. Ben-

Say you saw it in the Journal of the Michigan State Medical Society

nett, M.D., President of the Shiawassee County Medical Society, and by W. E. Barstow, M.D., St. Louis, Vice Chairman of The Council, Michigan State Medical Society.

Hardy A. Kemp, M.D., Dean, spoke in behalf of Wayne University College of Medicine, Dr. Hume's alma mater.

Dr. Hume was born in 1859 and has been practicing medicine since 1881. Over 300 persons from all walks of life gathered to do honor to Dr. Hume, a practicing physician in Owosso for over sixty-seven years.

* * *

Antihistaminic Drug.—Dr. Nathan Sperber, speaking at the annual meeting of the Division of Medicinal Chemistry of the American Chemical Society at the Hotel Hamilton, Chicago, described Trimeton, which has been extensively studied by leading allergists from coast to coast and found less toxic than the older products so far marketed. Although basically different in chemical structure than all other recently discovered antihistaminics, Trimeton has proved its effectiveness in hay fever vasomotor rhinitis, urticaria and other allergic states.

Experiments in the laboratory have shown that Trimeton in comparison with other known antihistaminics represents a major advance in the field of the "anti-allergic" drugs because it is low in toxicity, high in potency, and relatively free from those properties which from clinical experience with other drugs would be expected to exert undesirable side effects in human patients other than antihistaminic.

* * *

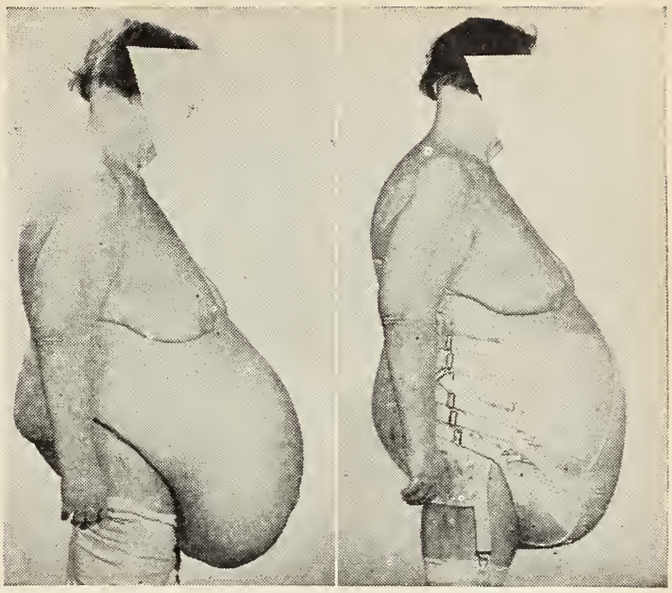
Infant Mortality.—The infant mortality rate in 1946 was 33.8 deaths under 1 year per 1,000 live births, or 11.7 per cent less than the rate of 38.3 in 1945, according to figures of the National Office of Vital Statistics. The number of infant deaths which occurred during 1946 was 111,036, or 6,379 more than during 1945. This rise reflects the tremendous increase in the number of births during 1946. The relative frequency of infant death, as measured by the infant mortality rate, decreased.

The infant mortality rates shown here are the number of deaths under 1 year of age during a given year per 1,000 live births which occurred during that year. This rate is influenced by changes in the annual number of births. In years such as 1946, in which the number of births increased appreciably from the preceding year, the rate is understated.

The five leading causes of death during infancy, and the infant mortality rate in 1946, were: premature birth —12.1, congenital malformations—4.5, pneumonia and influenza (combined)—3.8, injury at birth—3.6, diarrhea, enteritis, and ulceration of the intestines (combined)—1.7.

* * *

The U. S. House of Representatives reduced the appropriation for the Office of the Social Security Commissioner from $3,131,165 to $221,000 with large reductions in funds for research and informational services. This was accomplished by the transfers of various activities to the Federal Security Administrator and operating divisions. In effect, this would involve a major re-



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organization of the Social Security Administrative structure.

As compared with a requested appropriation of $3,131,165, the House allowed a total of $2,573, 549 of which all but $221,000 was transferred either to the Federal Security Administrator or to operating bureaus.

The bill is now in the U. S. Senate.

Representative Dingell criticized the reduction in the research staff (headed by I. S. Falk) from fifty to twenty employes, as follows:

> "The Bureau of Research and Statistics is at one and the same time the brain, the heart, and the nerve center of the social security program. This office conducts the basic studies necessary to analze the existing coverage of social security and the deficiencies and mistakes that may become apparent at operating levels. It supplies the committees of Congress with information upon which to legislate and to appraise the need for expansion of social security coverage. To reduce this research staff from fifty to twenty employes can be justified only upon the assumption that a Republican Congress either is not going to enact any progressive social security legislation or that they want to legislate in an uninformed vacuum."

* * *

Mr. Henry L. Black, of Battle Creek, of the Professional Management, gave a series of three lectures to the first-year interns and young doctors at the University of Michigan in May on the "Business Side of Medicine."

This was a part of the course on Economic Medical Education sponsored by the Michigan State Medical Society.



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20,000 YEARS OF SERVICE. A photographic and biographic account of members of the Medical Society of the State of New York who have practiced forty years.

The Medical Society of the State of New York has bestowed upon each member who has practiced medicine for fifty years a certificate signed by the president. There are 432 physicians in New York State who have practiced for more than fifty years. A booklet has been published giving the picture before and after of forty-eight members, and pictures of 322 members who did not supply early pictures. Each of these pictures was accompanied by a short biography. This is a very interesting and valuable memento.

* * *

HISTORY OF THE MEDICAL SOCIETY OF THE COUNTY OF WESTCHESTER 1797—1947. A compilation from the available minutes of the Society and various contemporary sources during the years for which the minutes were lost. Published by the Medical Society of the County of Westchester, 1947.

The Comita Minora of the Westchester County Medical Society of the State of New York authorized the publication of a history of the society at the 150th Anniversary. The volume produced is worthy of the effort, making a storehouse of historical information which might have become lost—the actions of the society, its officers, its representatives in military service. Varied

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Fractures and Traumatic Surgery—Intensive Course, two weeks, starting June 7, October 25.

OPHTHALMOLOGY—Intensive Course, two weeks, starting September 20.
Refraction Methods, four weeks, starting October 11.
Ocular Fundus Diseases, one week, starting June 7, November 15.

GYNECOLOGY—Intensive Course, two weeks, starting September 13.
Vaginal Approach To Pelvic Surgery, one week, starting September 27.

OBSTETRICS—Intensive Course, two weeks, starting June 21, September 27.

MEDICINE—Intensive Course, two weeks, starting October 11.
Personal Course In Gastroscopy, two weeks, starting June 28, July 12.
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interests are indicated by the note in 1923 "On January 11, French and Belgian troops began the occupation of the Ruhr. In Westchester County an epidemic of measles and scarlet fever was reported by the Public Health Committee to the Society." Again, in 1923: "It is interesting to note here that on March 9, of this year, was ended the revolt in Bavaria organized by General Ludendorff and Adolph Hitler in Munich. Ludendorff was captured when the Beer Putschists marched, Hitler wounded." This book is full of interest and references, a pleasure to read.

ENCYCLOPEDIA OF MEDICAL SOURCES. By Emerson Crosby Kelly, M.D., F.A.C.S., Associate Professor of Surgery, Albany Medical College; Attending Surgeon Albany Hospital; Editor, Medical Classics. Baltimore: The Williams & Wilkins Company, 1948. Price, $7.50.

This book is unique. The author, in his preface, tells of helping his chief publish a book, Surgical Diagnosis, and misplacing McBurney's point. When discovered, a search showed 50 per cent of references made the same mistake. He noticed references to a certain sign "Homan's sign," and could not find it. Therefore, for many years, he has kept a list of references, and has compiled a valuable book of nearly 500 pages, two columns, containing an alphabetical list of names, giving the address, and classification as physician, physicist, surgeon, et cetera, then a description of the "test," "operation," "sign," "method," disease," "theory," "law," "technic," "medium," or whatever term is required. Almost everything imaginable dealing with medical matters is included, with

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the reference to publication. This volume would be invaluable in a reference library, or for anyone who is a close reader of medicine.

BRIEF PSYCHOTHERAPY. A Handbook for Physicians on the Clinical Aspects of Neuroses. By Bertrand S. Frohman, M.D., with the collaboration of Evelyn P. Frohman. Forward by Walter C. Alvarez, M.D. 260 pages. Philadelphia: Lea & Febiger. 1948. Price, $4.00.

This handbook of treatment "was planned and written to aid physicians in detecting and managing the underlying psychological factors which are masked by functional disturbances." This volume contains brief descriptions of a large number of syndromes of emotional and psychosomatic illnesses. The large number of syndromes discussed necessitates very brief treatment of any one syndrome and makes the presentation of illustrative case material so brief that it is almost inadequate.

Careful study of the book should give a general practitioner a speaking knowledge of the subject, but this reviewer doubts that any good understanding of the basic principles involved can be presented in a handbook of this sort. It can be said that the material is presented in an interesting and readable fashion. This reviewer is in emphatic agreement with the thesis of the book, i.e., that the general practitioner and the internist should have an understanding of the basic principles of psychosomatic illnesses. On the other hand, the well-trained psychiatrist can and should take issue with the implication in the foreword that only the general practitioner or the internist is in a position to understand and treat psychosomatic disorders.

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BULLETIN, AMERICAN COLLEGE OF RADIOLOGY. Chicago, 1948.

This is an annual book listing the officers, committees, medalists; president's address and reports of the committees and commissions; the Constitution and By-Laws; a roster of the members, fellows and life members, also a geographical listing.

PSYCHOBIOLOGY AND PSYCHIATRY. A Textbook of Normal and Abnormal Human Behavior. By Wendell Muncie, M.D., Practicing Psychiatrist; Chairman, Medical Advisory Board, Seton Institute, Baltimore, Md.; Associate Professor of Psychiatry, Johns Hopkins University; Consultant in Psychiatry, U.S.V.A. Second Edition. With 70 illustrations. St. Louis: The C. V. Mosby Co., 1948. Price, $9.00.

The second edition of Psychobiology and Psychiatry brings a revised edition of a basic test in psychiatry. Dr. Muncie was a long-time associate of Adolph Meyer and is probably one of his outstanding disciples. The contributions to American Psychiatry by Dr. Meyer and his group are numerous and of considerable value and the revision of this textbook describing Dr. Meyer's approach is a welcome addition to the physician's library.

There are a number of important and significant changes. The bibliography throughout the volume has been revised and brought up to date and includes certain divergent viewpoints. The newer army classification of psychoneurotic disorders is included and compared with that of Kraepelin, Freud and Meyer. There are certain changes in the chapter on psychoneurosis as well as a new chapter on the psychosomatic disorders. In the section on treatment certain significant additions will



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also be found. These include chapters on shock treatment, mental hygiene and on treatment of the convulsive disorders. An interesting subsection enumerates criteria for hospitalization as the method of choice in treatment. In summary one can say that the additions and revisions have added considerable to the value of an important and basic textbook. F. O. M.

MALE HORMONE THERAPY. A Refresher Course. Free upon request. Summit, N. J.: 1948. The Ciba Pharmaceutical Products, Inc.

This is a compilation of recent and reliable articles in standard medical publications. It is designed to provide a comprehensive reference to the experimental work as well as the therapeutic uses of the male sex hormone.

THE ACUTE BACTERIAL DISEASES.—Their Diagnosis and Treatment. By Harry F. Dowling, M.D., F.A.C.P., Clinical Professor of Medicine, George Washington University; Chief, George Washington Medical Division, Gallinger Municipal Hospital. With the Collaboration of Lewis K. Sweet, M.D., Chief Medical Officer in Pediatrics and Infectious Diseases, Gallinger Municipal Hospital; Adjunct Clinical Professor of Pediatrics, George Washington and Georgetown Universities; and Harold L. Hirsh, M.D., Assistant Professor of Medicine, Georgetown University; Director of the Bacteriology and Immunology Laboratory, Georgetown University Hospital. 465 pages with 55 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.50.

The book starts off with a general consideration of diagnosis of acute bacterial disease and general measures in treatment of infectious diseases. Serum therapy, the sulfonamides and their use in therapy, are followed by similar consideration of penicillin and streptomycin. The rest of the book is devoted to the diseases caused by cocci, by bacilli, and the bacterial diseases in which

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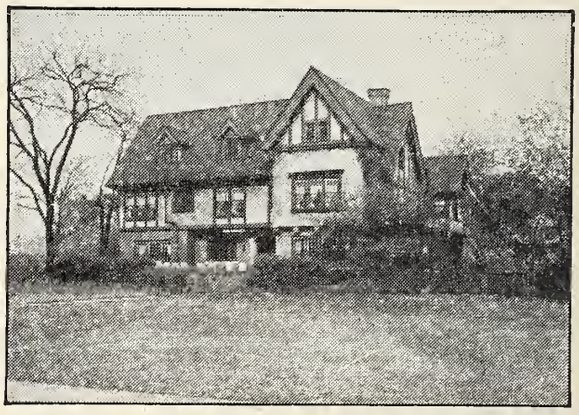
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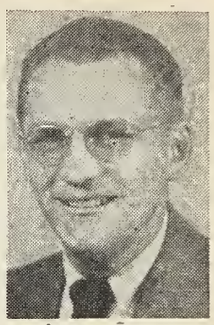
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Please Meet...

JOHN HOGAN

John Hogan, who joined the staff of the Battle Creek office in 1947, after four years in the Army Air Forces, including service in India and Tinian. He attended the University of Notre Dame and Kalamazoo College. His hobbies are photography and fishing.



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TAKING THE CURE: The Patients Approach to Tuberculosis. By Robert G. Lowell, M.D. University Hospital, University of Michigan, Ann Arbor, Mich. Illustrated by Donald Gooch. New York: The Macmillan Co., 1948. Price $2.00.

This is a small book, written for the tuberculous patient who has just entered the hospital, or whose condition has just recently been diagnosed. The author describes the technique of living in bed, how to get along with other persons likewise hospitalized and undergoing strange controls. It tells the patient what is expected of him, and makes his co-operation less irksome.

* * *

A.D.A. FORECAST. A new monthly magazine published by the American Diabetes Association for the general public.

This copy contains several articles, written for easy lay reading, by such men as Elliott P. Joslin, Herman O. Mosenthal, and Joseph H. Barach. Also other articles by laymen or dietitians. Pocket size and easily carried or referred to.

DERMATITIS FROM WEARING APPAREL

(Continued from Page 628)

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WANTED—Doctor to locate in Thompsonville, Michigan. General practice opportunity excellent. Good roads, two railroads, modern conveniences. Several smaller communities within radius of 20 miles. Population 350. Hospital facilities at Frankfort, Traverse City, Manistee—within 30 miles. Housing facilities good. No doctor practicing here at present time. For further information, contact Thompsonville Chamber of Commerce.

WANTED—Young physician especially trained in general and traumatic surgery to become associated with a group well established in metropolitan area of Detroit. Salary at least $6,000 a year, with a guarantee of $10,000 a year, and the position will lead to partnership. Write THE JOURNAL, Michigan State Medical Society, Box 47, 2020 Olds Tower, Lansing 8, Michigan.

TOWN of 500 people in a lucrative dairy community needs a physician badly. None within a radius of 10 to 35 miles. Housing available. Peck is considered the busiest little town in the thumb district. For further information, contact Mrs. C. E. Raft, 105 East Lapeer Avenue, or phone 3701 or 9131, Peck, Michigan.

PRACTICE FOR SALE—An eye, ear, nose and throat practice of twenty-five years' duration in Alpena, Michigan. Office fully equipped. Reason—death. Write or phone for appointment. Mrs. W. B. Newton, 715 Washington Avenue, Alpena, Michigan. Phone 238.

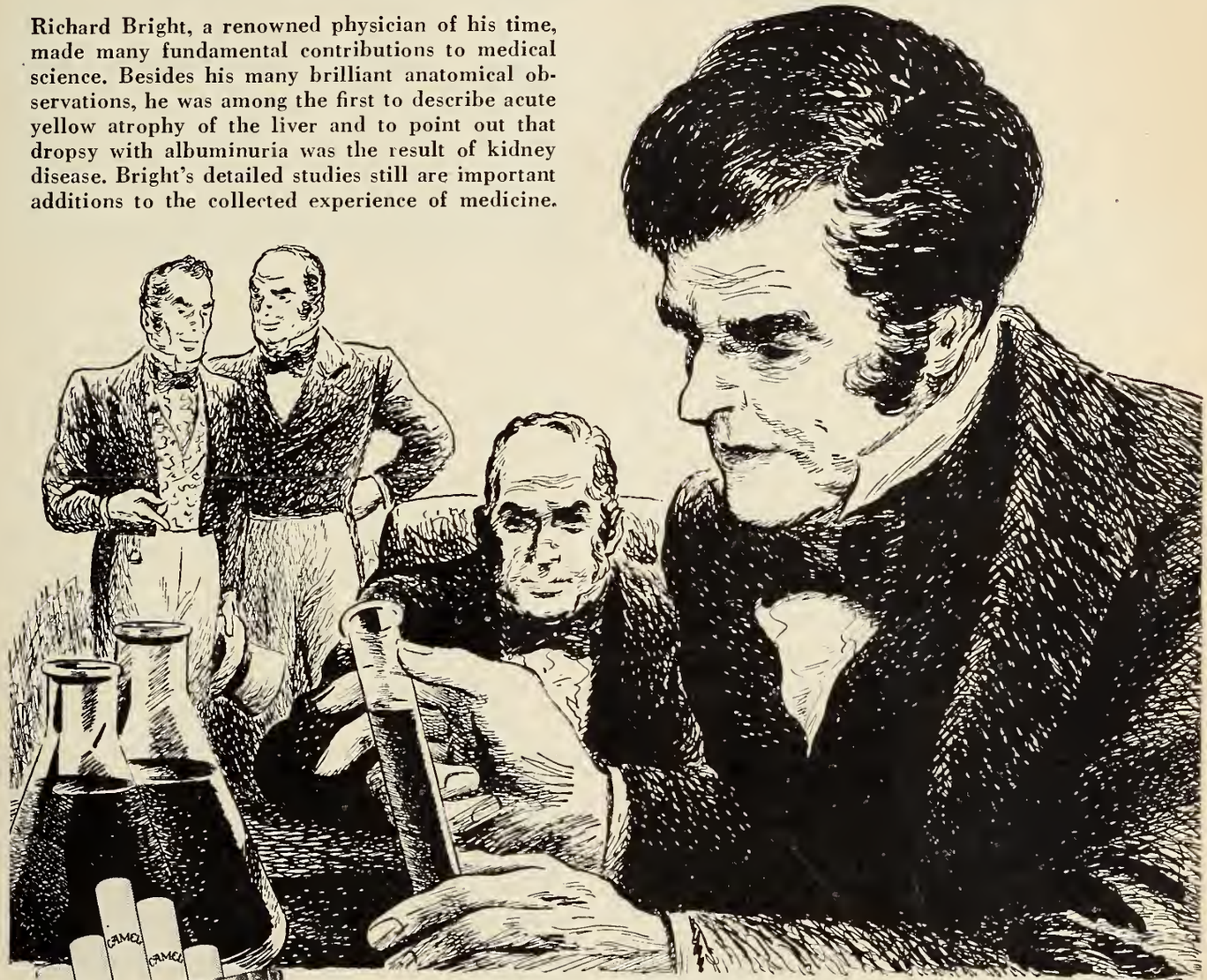
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Richard Bright, a renowned physician of his time, made many fundamental contributions to medical science. Besides his many brilliant anatomical observations, he was among the first to describe acute yellow atrophy of the liver and to point out that dropsy with albuminuria was the result of kidney disease. Bright's detailed studies still are important additions to the collected experience of medicine.



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Three independent research organizations in a nationwide survey asked 113,597 doctors what cigarette they smoked. The brand named most was Camel!

Cancer Comment

CANCER CONTROL ORGANIZATIONS IN MICHIGAN

The past two decades have seen a growing interest in the development of a well integrated program for cancer control in Michigan. In 1930 the Michigan State Medical Society appointed its first cancer committee to study the distribution and extent of facilities for diagnosis and treatment of cancer in this State.

In 1936, the Women's Field Army of the American Society for the Control of Cancer (now known as the American Cancer Society) was organized to carry on lay educational and fund raising campaigns under proper medical guidance and control.

In 1939, State funds were first appropriated to the Michigan Department of Health for cancer control purposes.

For several years these three organizations continued a rather independent existence and it was not until 1946 when the present Cancer Control Committee of the Michigan State Medical Society was appointed, with members representing each of the three organizations previously mentioned, that a unified cancer control program was developed.

The Cancer Control Committee's subcommittees on Education, Ways and Means, and Fact Finding serve both lay and professional groups throughout the State. To expedite the work of these subcommittees a central office with a full-time medical secretary is maintained.

There are two independent co-ordinate divisions of the American Cancer Society in Michigan: the Michigan Division, with headquarters in Grand Rapids, comprising the State outside the Detroit metropolitan area; and the Southeastern Michigan Division comprising Macomb, Oakland and Wayne counties, with headquarters in Detroit. Each division has an independent budget and program. Educational and service activities are guided by a committee of physicians representative of the geographical areas served.

The Michigan Division has a local division in almost every county. A committee, acceptable to the local medical society and composed largely of its own members, directs local cancer control projects which vary in different counties from educational programs to providing needed hospital equipment for cancer diagnosis and treatment and financial subsidy to physicians and nurses wishing to take postgraduate study in the cancer field.

The Southeastern Division, in addition to carrying out a program similar to that described above, supports the research program of the Detroit Institute for Cancer Research. The Institute expects in time to employ 25 or more scientists. It also obtains financial support from the American Cancer Society and the United States Public Health Service. The Institute is affiliated with Wayne University Medical School for undergraduate and postgraduate medical teaching.

The Michigan Cancer Foundation has been chartered in Detroit to accept and administer funds given by trusts and individuals for cancer control purposes in that area. Its activities are closely allied with those of the Southeastern Division of the American Cancer Society.

The Michigan Department of Health engages in lay educational work and contributes its cancer funds, both State and National, largely to the support of cancer programs through local health departments and to the educational program of the Cancer Control Committee.

Of funds collected each year by the Michigan Division of the American Cancer Society, 40 per cent is sent to the National headquarters of the Society where 25 per cent is allocated to the support of research, the other 15 per cent to general overhead expenses of the parent organization. Sixty per cent of the collected funds remain in the State, of which 10 per cent is allocated to expenses of the State office in Grand Rapids, 5 per cent to the Cancer Control Committee, and the remaining 45 per cent to projects in the local community where the funds were obtained.

Aside from expenses of maintaining its headquarters and of conducting its educational and service program, funds of the Southeastern Division are used largely in support of the program of the Detroit Institute for Cancer Research.

It is hoped this explanation of the activities of various organizations in the cancer field in Michigan will prove of interest and will help readers to

(Continued on Page 828)

EFFECTS OF INFECTIOUS DISEASES AND TRAUMA ON BODY PROTEIN

There are two large groups of disorders which produce generalized protein breakdown: *infections*, acute and chronic, and *trauma*. Infections usually produce fever. A rise in temperature of one degree Fahrenheit means a seven to ten per cent rise in metabolic rate. In addition, bacterial toxins may cause protein breakdown by affecting the cells directly. For these reasons, loss of weight is an outstanding feature of infectious diseases. Diet, especially during convalescence, is therefore high in calories and in the *proportions of protein*. Certain types of injury produce an intense protein *breakdown* which may last for several weeks. The negative nitrogen balance which follows injury is difficult to counteract. *Extremely high protein intakes* are needed to minimize the loss of body tissue.*



*"*The Importance of Protein Foods in Health and Disease"—new physicians' handbook on protein-feeding. Prepared by a physician, in conjunction with the Nutrition Division of Swift & Company, this booklet will be sent you on request. Simply fill out the coupon.*



SWIFT'S STRAINED MEATS

Palatable protein supplementation for patients on soft, smooth diets

When surgery, disease or trauma creates a problem in protein supplementation, many physicians now use Swift's Strained Meats. These all-meat products provide a palatable source of complete, high-quality proteins, B vitamins and minerals. Originally developed for infant feeding, the meats are strained fine — may easily be used in tube-feeding or for oral feeding in soft diets. Swift's Strained Meats are convenient to use — ready to heat and serve. Six kinds provide variety and tempting flavors that help combat anorexia: beef, lamb, pork, veal, liver and heart. 3½ ounces per tin.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of June 16, 1948

- Monthly financial reports and bills payable were presented, studied, and approved.
- Chairman and secretaries of the General Assemblies, as well as Discussion Conference Leaders for the Detroit, 1948, MSMS Annual Session, were appointed.
- Suggestions for selection of the 1948 Biddle Lecturer were given to President P. L. Ledwidge, M.D., at his request.
- Wm. A. Hyland, M.D., Grand Rapids, was chosen as chairman of the 1949 Michigan Postgraduate Clinical Institute, scheduled for the Book-Cadillac Hotel, Detroit, March 23-24-25, 1949.
- The suggestion of an orientation course for new members of county medical societies was referred for study to the County Societies Committee of The Council.
- Four changes in the Uniform Fee Schedule for Governmental Agencies were approved and a reprinting of the Fee Schedule was authorized.
- The schedule of the mid-summer meeting of The Council, July 22-23-24, 1948, was developed and approved.
- The Executive Committee authorized mailing of the MSMS Annual Session Program to all AMA members in Michigan, northern Ohio and Indiana, eastern Wisconsin, and to CMA members in Ontario.
- E. F. Sladek, M.D., Traverse City, and H. H. Cummings, M.D., Ann Arbor, were authorized to attend the meeting of the Associated States Postgraduate Committee in Chicago, June 23, as MSMS representatives.
- A letter of congratulations to Paul D. Bagwell, Lansing, president of the United States Junior Chamber of Commerce, was authorized.
- AMA health coverage of its employes was discussed and the contract between the AMA and an insurance company was presented and studied. Correspondence with AMA Secretary re the Board of Trustees' action on this matter was reviewed.
- The monthly reports of President P. L. Ledwidge, M.D., Detroit, of President-elect E. F. Sladek, M.D., Traverse City, of Secretary L. Fernald Foster, M.D., Bay City, and of Editor Wilfrid Haughey, M.D., Battle Creek, were presented and appropriate action was taken on various recommended projects.
- The Executive Committee approved the designation of the October, 1948, JMSMS as a special Venereal Disease Control Number, as recommended by Editor Haughey.
- The MSMS Committee on Emergency Medical Service was authorized to confer with Governor Kim Sigler regarding state-wide organization and medical protection against an atomic bomb attack. C. E. Umphrey, M.D., Detroit, was confirmed as a member of this committee.
- Reports accepted from Committee on Constitution and By-Laws, Maternal Health Committee, Heart and Degenerative Diseases Committee, Rheumatic Fever Control Committee, Venereal Disease Control Committee, and Distribution of Medical Care Committee.
- The Wayne County Medical Society's Rules and Regulations for Cancer Detection Centers were authorized to be published in JMSMS.
- The Public Relations Counsel reported that the MSMS motion picture "Lucky Junior" would be previewed by the Committee on Cinema on July 2; that the pamphlet "Your Child Is Safer in Michigan" has been revised, reprinted, and that 80,000 copies of the booklet were distributed by Michigan theaters booking the heart film "Be Your Age"; MSMS PR department co-operated with the American Medical Association and the Michigan Congress of Parents and Teachers in developing a scientific display used at the AMA convention in June, 1948, Chicago; the "Medical Associates" brochure will be ready for distribution in September to the MSMS House of Delegates, and for general use in high schools, junior colleges, and colleges; the "Tell Me, Doctor" program is being heard over twenty-two Michigan stations, *daily;* a suggested plan for Woman's Auxiliary action in public relations has been completed, for distribution by the Woman's Auxiliary to its members.

(Continued on Page 828)



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The extra long action of Neo-Synephrine hydrochloride makes possible control of hay fever symptoms with infrequent dosage, thus enabling the patient to be comfortable during the day and obtain sleep at night.

Average dose: 2 or 3 drops in each nostril.

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

(Continued from Page 826)

- The second Michigan Rural Health Conference's Committee on Arrangements reported plans for the Conference on September 16-17, 1948, in East Lansing. Forty co-operating agencies, all interested in rural health, will sponsor the second Rural Health Conference.
- Reports on work of the Medical Jurisprudence Committee of the State Bar of Michigan (on which two MSMS representatives are members) was given; also progress report on reactivation of Michigan Health Council of which A. S. Brunk, M.D., Detroit, is president.

A MINIMUM LEVEL OF MISERY!

"Social security is a device whereby the modern state makes certain that all its people shall enjoy a minimum level of well-being . . . what we have come to call social security is the means whereby the modern state assures equitable distribution of the goods and services its people produce."

Wilbur Cohen, technical assistant to A. J. Altmeyer of the Social Security Board and Assistant Director of Research and Statistics under I. S. Falk, made this statement in an article of the March, 1948, issue of the *Social Security Bulletin*!

PROPOSED REVISION OF MSMS CONSTITUTION AND BY-LAWS

A complete revision of the MSMS Constitution and By-Laws, recommended by the Special Committee on Constitution and By-Laws of which T. K. Gruber, M.D., Eloise, is chairman, will be referred to the MSMS House of Delegates at its session at the Book-Cadillac Hotel, Detroit, September 20-21, 1948. In accordance with the Constitution, these proposed amendments were published in two issues of JMSMS—in the January, 1948, Number, beginning at Page 78; and in the June, 1948, Number, beginning at Page 657.

CANCER DETECTION CENTERS

Rules and Regulations Adopted by the Wayne County Medical Society

1. These Clinics shall be for educational and screening purposes only.
2. There shall be no distinction between indigent or non-indigent patients. On an educational basis, this is only a problem of referral; the non-indigent are sent to private physicians, the indigent to tumor clinics or other organizations set up to provide medical care for this group.
3. Examination shall be the same in all hospitals.
4. The examination shall only consist of:
   (a) Complete history and a physical examination.
   (b) There shall be no laboratory work.
5. There shall be no treatment given at any of these clinics.
6. The present title "Cancer Detection Clinic" is a misnomer and shall be changed to "Cancer Detection Center" or "Cancer Center."

PEDIATRICIANS AGAINST FEDERAL AID FOR MEDICAL EDUCATION

The Executive Board of the American Academy of Pediatrics adopted a resolution, at its June 26-27 meeting in Chicago, "that the Executive Board, following a recommendation to this effect by the Committee for the Improvement of Child Health, has agreed that attempts to seek federal aid be held in abeyance pending the outcome of the plan proposed by the Council on Medical Education and Hospitals of the American Medical Association to establish immediately a national foundation, the purpose of which is to secure contributions from the general public for the support of medical education."

CANCER CONTROL ORGANIZATIONS IN MICHIGAN

(Continued from Page 824)

better understand the situation and the part each organization plays in it. Co-ordinated effort on the part of the Michigan State Medical Society, the two Divisions of the American Cancer Society, the Michigan Department of Health, and such other co-operating organizations as may enter the picture later, should give Michigan an effective cancer program.

Hematuria is the most common initial symptom of cancer of the bladder.

. . .

Thousands of people who have had cancer are alive and well today, but millions have died because of ignorance, delay and fear.

. . .

The first treatment given cancer patients should be the correct treatment.

. . .

Over 90 per cent of patients with cancer of the tonsil do not receive treatment for cancer until the lesion has reached a diameter of 4 cm.

. . .

Sore throat is the most common first complaint of the patient with tonsillar cancer.

. . .

Biopsy is a "must" for the correct diagnosis of cancer.

. . .

The diagnosis and treatment of cancer is not a one-man job.

Excellent results

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is well tolerated, there usually being "complete absence of side reactions if minimal effective doses are administered."[2] An additional asset of ESTINYL therapy is the "sense of well-being"[6] it commonly evokes.

DOSAGE: One ESTINYL Tablet, 0.02 mg., or one teaspoonful of ESTINYL LIQUID daily. In severe cases two to three tablets daily, or their equivalent in ESTINYL LIQUID may be prescribed, reducing dosage as symptoms subside.

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ESTINYL LIQUID, 0.03 mg. per 4 cc. (teaspoonful), in bottles of 4 and 16 oz.

BIBLIOGRAPHY: 1. United States Dispensatory, ed. 24. Philadelphia, J. B. Lippincott Company, 1947, p. 1446. 2. Wiesbader, H., and Filler, W.: Am. J. Obst. & Gynec. **51**:75, 1946. 3. Allen, W. M.: South. M. J. **37**:270. 1944. 4. Lyon, R. A.: Am. J. Obst. & Gynec. **47**:532, 1944. 5. Groper, M. J., and Biskind, G. R.: J. Clin. Endocrinol. **2**:703, 1942. 6. Soule, S. D.: Am. J. Obst. & Gynec. **45**:315, 1943.

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PR in Practice

There are now twenty-two Michigan radio stations carrying the "Tell Me, Doctor" show. The stations are WELL Battle Creek, WATZ Alpena, WHLS Port Huron, WHDF Calumet, WJIM Lansing, WMPC Lapeer, CKLW Detroit, WMBN Petoskey, WKZO Kalamazoo, WMRP Flint, WATT Cadillac, WHFB Benton Harbor, WMIQ Iron Mountain, WOAP Owosso, WLAV Grand Rapids, WJPD Ishpeming, WDMJ Marquette, WBCM Bay City, WBIM Jackson, WDBC Escanaba, WTCN Traverse City, WHRV Ann Arbor.

In addition the "Tell Me, Doctor" program is sponsored over four stations in Oklahoma by the Oklahoma State Medical Society; six stations in Virginia by the Medical Society of Virginia; and one station in West Virginia by the Kanawha County Society.

* * *

A three-column feature article, with pictures, on Medical Associates was released in matrix form to all Michigan newspapers. Many have already printed this article.

Over 200 interviews have been obtained for the Michigan Health Survey. A copy of the questions being asked on this survey may be obtained by writing to MSMS, 2020 Olds Tower, Lansing, Michigan.

* * *

Fourteen scripts have been completed for the Sex Education Program, and a teacher's guide is now being prepared to accompany the scripts.

* * *

Cancer Control will be the topic of the next newspaper advertisement.

* * *

The Woman's Auxiliary has just completed a comprehensive public relations program. It contains PR material on such specific projects as the popularization of Health and Immunization Months, promoting Nurse Recruitment, and assisting Blue Cross Community Enrollment Drives.

* * *

The Second Annual Michigan Rural Health Conference will be held September 16 and 17 on the campus of Michigan State College, East Lansing. A meeting of the sponsors was held on July 14 to plan the program and make arrangements for the Conference.

A brochure on the First Annual Michigan Rural Health Conference has been published and distributed. The booklet gives a complete summary of the proceedings of the conference. For a copy write H. B. Zemmer, M.D., Chairman, Michigan Rural Health Conference, 2020 Olds Tower, Lansing, Michigan.

* * *

The MSMS motion picture "Lucky Junior" was previewed for the MSMS Committee on Cinema at the Jam Handy Studios in Detroit on July 2, and it was enthusiastically received. The picture will be previewed shortly in a regular Detroit theater to get the public's reaction to the picture before general release to 400 theaters.

* * *

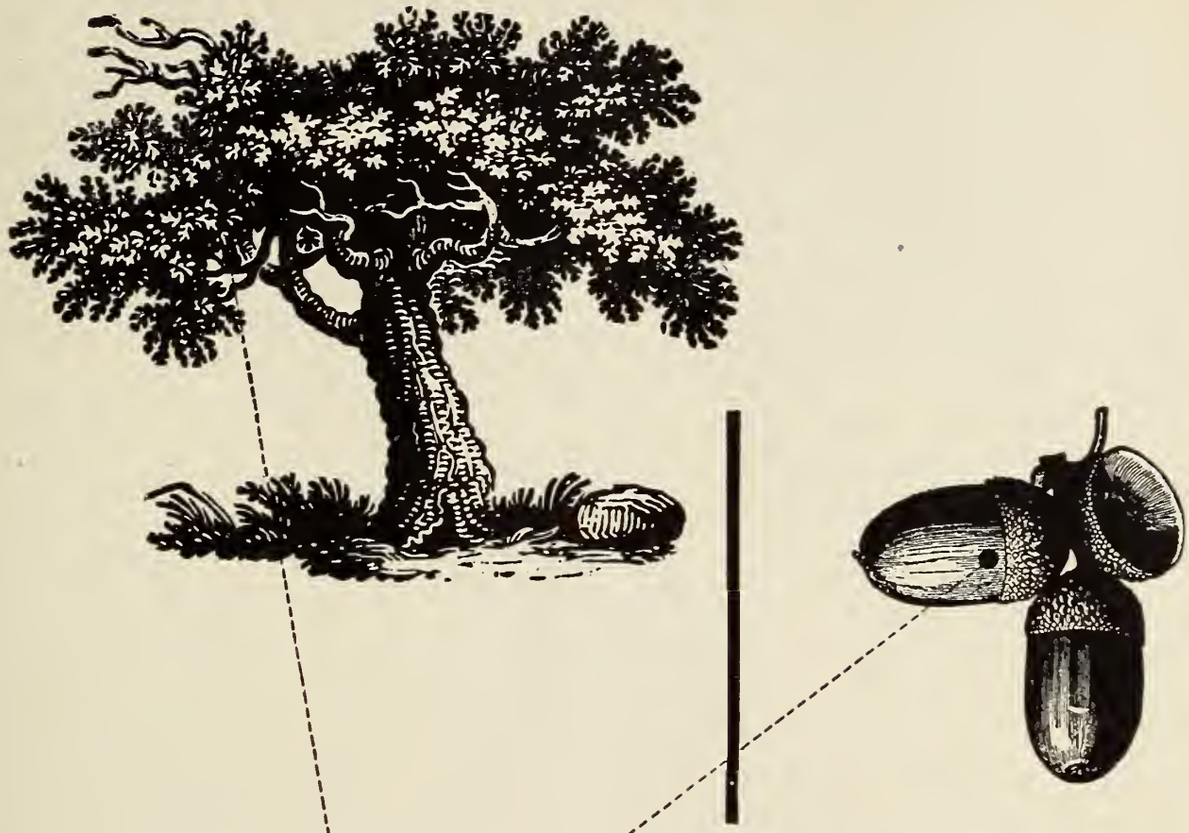
Over 80,000 copies of the booklet "Your Child Is Safer in Michigan" have been distributed through the motion picture theaters of Michigan in conjunction with the heart picture "Be Your Age." More than 288 theaters have booked this picture to date. It carries a trailer outlining the work of the MSMS in establishing Rheumatic Fever Control Centers and crediting the MSMS, the Michigan Foundation for Medical and Health Education, the Michigan Society for Crippled Children and Adults, and the Michigan Department of Health as co-sponsors of the film.

* * *

The MSMS Public Relations department is compiling a library of photographs of members. At the present time there are over 1,000 pictures of individual doctors in our files, as well as 200 general pictures of interesting health subjects. We would like to have a picture of every doctor in the Society. If you have a portrait of yourself or photo of some health activity, please forward a glossy print of it, with your name and address on the reverse side, to MSMS, 2020 Olds Tower, Lansing 8, Michigan. Many thanks.

* * *

Each month a feature article is reprinted from The Journal of the MSMS and distributed to interested parties. Reprints to date include Rheumatic Fever, Easter Seals, Cancer Control, Michigan's Foremost Family Physician (T. E. DeGurse, M.D.), and one on The Journal itself. For reprints of any of these or of future features, write to Public Relations Department, 2020 Olds Tower, Lansing 8, Michigan.



Not all little acorns into great oaks grow.

Nor do all little children reach optimal height.

Nutritional elements absolutely essential to optimal growth and function are today available in convenient economical forms. Vitamins D and A—alone or combined with other growth and health promoting vitamins —are provided in potencies suited to supplementation, maintenance, and prophylaxis through infancy, childhood, adolescence, and adulthood, for as long as growth and life persist.

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fine pharmaceuticals since 1886

Upjohn Vitamins

Farm Enrollment in MMS

Increased interest in the surgical and the medical-surgical care programs of Michigan Medical Service has been evidenced this spring among Farm Bureau groups in the state. Recent figures compiled for the period of January 1 through May 30 show that out of 86 new Farm Bureau groups enrolled in the Blue Cross Plans, seventy-nine were enrolled in both Michigan Hospital Service and Michigan Medical Service.

Sixty of these groups were enrolled for the surgical care plan and nineteen were enrolled for the medical-surgical plan of Michigan Medical Service.

Also during the same period, thirty-six old Farm Bureau groups, which had been protected by only the Blue Cross hospital care plan, added the surgical plan, and eighteen old groups added the medical-surgical plan.

Altogether, 133 Farm Bureau groups were enrolled in, or added, the surgical or medical-surgical care plans to their Blue Cross protection between January 1 and May 30.

This increasing interest in Michigan Hospital Service and Michigan Medical Service among Farm Bureau groups is due largely to the personal interest and efforts of Farm Bureau officers, according to the service plans' officials. State, district, county and local officers of the Farm Bureaus handled much of the work of the annual re-enrollment among Farm Bureau Discussion Groups in May. These officers conducted what was practically a person-to-person campaign, and results show that around 2,000 Farm Bureau families who were members of protected groups had been waiting for the re-enrollment period in order to apply for membership in the Blue Cross Plans.

Approximately 8,000 additional members from Farm Bureau groups were enrolled during this re-enrollment period. Total enrolled members in the Blue Cross Plans, as represented by 545 Farm Bureau Discussion Groups, is now more than 29,000 persons.

Military Medicine

NAVY'S NEW MEDICAL TRAINING PROGRAM

The Surgeon General of the Navy has announced the expansion of the Bureau's professional training program for reserve and regular medical officers, which is similar to the recently expanded Army medical training program. The object is to permit more Navy doctors to meet the requirements for certification by the various American Specialty boards, and to encourage the young doctor to intern under the auspices of the Navy. The following are the important points in this program:

Graduates of Class A medical schools who have been accepted for internship by a hospital approved for such training by the Council on Medical Education and Hospitals of the AMA may be commissioned as lieutenants (junior grade), MC, USNR, and permitted to continue their intern training. They will receive all the pay and allowance of the rank while so serving. After completing their internships, the medical officers must remain on active duty for a period of one year. If they meet the professional, physical and moral requirements, they will be given every encouragement to transfer to the regular Navy.

Interns who have completed the one year of obligated service, and who have transferred to the regular Navy, may be considered for residency training on a competitive basis with other officer personnel of the regular Medical Corps.

Resident physicians now in civilian hospitals, or those accepted for approved residency training, are eligible for commissions in the regular Navy. Those so commissioned will be assigned to duty, with full pay and allowances, in the hospital in which they are already a resident, or to which they have been accepted for residency training. Every attempt will be made to permit residents holding commissions in the regular Navy to complete their training in event of an emergency.

The Navy has at the present time 400 approved residencies and fellowships in the various specialties recognized by the American Specialty Boards in Naval and civilian hospitals. This educational training involving the 400 residencies is divided into two programs.

Program A: One hundred of the above-mentioned residencies, courses, and fellowships will be made available for civilian physicians accepting a commission in the U. S. Navy. An additional 100 civilian physicians will be commissioned in the U. S. Navy and permitted to pursue their own course, fellowship or residency, provided it is approved by the Council on Medical Education and Hospitals of the American Medical Association

(Continued on Page 877)



The Petechiometer* a Rexall exclusive

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DRUGS

YOU CAN DEPEND ON ANY DRUG PRODUCT THAT BEARS THE NAME REXALL.

The Petechiometer—exclusive with Rexall—is a new device used in the measurement of capillary fragility. It is a simplification of the suction-type resistometer used in the Dalldorf test.

A small suction pump with a spring-returned plunger and clear plastic suction cup, the Petechiometer applies negative pressure to a hairless area of skin two centimeters in diameter. A magnifying glass blown into the upper surface of the cup helps count petechiae which develop.

The air is expelled from the suction cup by pressure of thumb on plunger. The cup is then placed lightly but firmly upon the skin. As thumb pressure is released, spring action applies suction. After one minute, suction is released; after five minutes, petechiae are counted. By moving an adjustable "stop" ring the test may be repeated at two additional suction levels. Remember that increased capillary fragility is a complication of many clinical conditions.

You can obtain the Petechiometer only at drug stores displaying the familiar blue and white Rexall sign—your assurance of drugs manufactured under rigid laboratory control, compounded with superior pharmacal skill. Your Rexall druggist will be glad to tell you more about the Petechiometer. Or write to Rexall Drug Company, Los Angeles, California.

**Petechiometer is a registered trade-mark owned by the Rexall Drug Company covering a clinical device for the measurement of capillary fragility.*

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LOS ANGELES, CALIFORNIA

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Say you saw it in the Journal of the Michigan State Medical Society

Michigan Attendance at AMA Annual Session

Chicago, Illinois, June 20-25, 1948

Sunday, June 20

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Douglas, Robert J., Muskegon, 4910 California
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Ensign, Dwight C., Detroit, Stevens
Frazer, Mary Margaret, Detroit, Blackstone
Golinvaux, C. J., Monroe, Stevens
Gruber, Thomas K., Eloise, Palmer House
Hartman, F. W., Detroit, Palmer House
Hasley, Clyde K., Detroit, Stevens
Hildreth, Roscoe Carson, Kalamazoo, Stevens
Hoobler, Sibley W., Ann Arbor, Stevens
Howes, Willard B., Detroit, Congress
Hudson, William A., Detroit, Congress
Jacobson, S. D., Detroit, Sherman
Jarre, H. A., Detroit, Palmer House
Johnston, Charles G., Detroit, Drake
Klein, Howard A., Detroit, Sherman
Kryixicki, F., Detroit, Stevens
Leucutia, Traian, Detroit, Hamilton
Marcus, Daniel B., Detroit, Sheraton
McGraw, Arthur B., Detroit, Lake Shore Drive
McKean, G. Thomas, Detroit, Palmer House
Meyers, Solomon George, Detroit, Knickerbocker
Murray, William A., Detroit, La Salle
Newman, Max Karl, Detroit, Morrison
Novy, R. Y., Detroit, Palmer House
Noer, Rudolf J., Detroit, Palmer House
Penzotti, Stanley C., Three Rivers
Penberthy, Grover C., Detroit, Palmer House
Pilling, Matthew A., Detroit, Sherman
Posch, Joseph L., Detroit, Palmer House
Robb, James Milton, Detroit, Lake Shore Club
Shapiro, Reuben I., Detroit, Congress
Steinberger, Eugene J., Detroit, Knickerbocker
Straith, Claire L., Detroit, Sherman
Strickroot, Fred L., Detroit, Knickerbocker
Stroup, Clayton King, Flint, Bismarck
Stryker, Homer, Kalmazoo
Sugar, David L., Detroit
Texter, Elmer C., Detroit, Palmer House
Thosteson, Geo. C., Detroit, Knickerbocker
Verhage, Martin D., Kalmazoo, Park Ridge, Ill.
Vollmar, G. Kenneth, Detroit, Stevens
Weed, Milton R., Detroit, Sherman
Wenzel, J. F., Detroit, Stevens
Wilensky, Thomas, Lansing, Stevens
Wilson, Walter J., Jr., Detroit, Sherman

Monday, June 21

Adams, Uriah M., Marcellus, Sherman
Ashley, L. B., Detroit, Allerton
Bankoff, Milton L., Michigan City, 125 E. 5 St., Mich. City, Ind.
Barker, Vincent L., Monroe, 7218 Yates Ave., Chicago
Broudo, Philip H., Detroit, Berkshire
Brunk, A. S., Detroit, Palmer House
Burnstine, Julius Y., Detroit, Sherman
Campbell, Mary B., Detroit, Blackstone
Candler, Clarence L., Detroit, Palmer House
Chambers, M. S., Flint, Stevens
Cheng, James T., Detroit, YMCA
Christian, Leo G., Lansing, Palmer House
Clausen, Claire H., Dearborn, Alexandria
Dean, Carleton, Lansing, Palmer House
De Pree, Joe, Grand Rapids, Sherman
Dickman, Harry M., Hudson, Atlantic
Dodrill, F. D., Detroit, Edgewater Beach
Dorniak, Ben P., Detroit, YMCA
Doty, Chester A., Detroit, Stevens
Doyle, Fred M., Kalmazoo, Congress
Droock, Victor, Detroit
Eisman, Clarence H., Detroit, LaSalle
Finton, Walter L., Jackson, Stevens
Freeman, Michael W., Detroit, Congress
French, Frank S., Detroit, Palmer House
Fliegelman, Maurice T., Ann Arbor, Sherman
Goodrich, Benjamin E., Detroit, Congress
Hailman, Harold F., Kalmazoo
Hammerberg, Kuno, Clare, 1319 Mandell St.
Harm, Winfred B., Detroit, Palmer House
Haughey, Wilfred, Battle Creek, Lake Shore Drive
Herrick, Ruth, Grand Rapids, Eastgate
Holly, Leland E., Muskegon, Sheraton
Holstein, Arthur F., Manchester, Palmer House
Horwitz, John B., Detroit, Stevens
Howard, W. Leonard, Northville, Congress
Huron, W. H., Iron Mountain, Palmer House
Jones, Bert Logan, Dearborn, Congress
Kahn, Reuben L., Ann Arbor, Sherman
Kelmensor, Victor A., Detroit, Congress
Kitchel, John H., Grand Haven, Palmer House
Krieg, Earl G. M., Detroit, Drake
Lam, Conrad R., Detroit, Lake Shore Drive
Ledwidge, P. L., Detroit, Lake Shore Drive
Lieber, R. W., Howell, Morrison
Lightboy, James, Detroit, Palmer House
Lindquist, Norman L., Escanaba, Belair
Lockwood, Bruce C., Detroit, Edgewater Beach
Luce, Hewey A., Detroit, Palmer House
Lutz, Earl F., Detroit, Drake
Maibauer, Frederick P., Wyandotte, Drake
Mehas, C. P., Pontiac, Congress
Miller, Jack L., Jackson, Bismarck
Murphy, Bernard M., Jackson, Bismarck
Pino, Ralph H., Detroit, Morrison
Podezwa, John W., Detroit, Morrison
Pratt, Jean Paul, Detroit, Palmer House
Rector, Frank L., Ann Arbor, 823 Case St., Evanston, Ill.
Rozan, Josef S., Lansing, Drake
Rulney, Max, Flint, 4711 N. Lawndale Ave.
Ruth, J. Griswold, Benton Harbor, Knickerbocker
Sauter, S. H., Detroit, Morrison
Schelm, G. W., Battle Creek, 901 Argyle St.
Sherwood, J. Vincent, Grand Rapids, Congress
Shurly, Burt R., Detroit, Palmer House
Siefert, John L., Detroit, Drake
Sippola, Geo. W., Detroit
Sladek, Edward F., Traverse City, Stevens
Smith, F. Janney, Detroit, Stevens
Smyth, Charley J., Plymouth
Somers, Donald C., Detroit, Drake
Sugar, Sam, Jackson, Atlantic
Thompson, Ralph M., Battle Creek, LaSalle
Tolwick, Edward T., Jackson, Morrison
Von der Heide, Elmore C., Detroit, Drake
Waldbott, Geo. L., Detroit, Stevens
Weller, Charles N., Detroit, Palmer House
Wells, Martha, Detroit, Stevens
White, Milo R., Detroit, Palmer House
Williams, C. J., Grone Point, Union League Club
Wright, D. R., Flint, Stevens
Yott, William J., Detroit, Stevens

Tuesday, June 22

Adams, Burnell H., Flint, Drake
Aimone, John Albert, Ludington, YMCA
Amos, T. G., Detroit, LaSalle
Anderson, H. B., Watervliet, Morrison
Arent, John Geo., Detroit, Rosemoor
August, Ralph V., Muskegon Hts., Sherman
Bacon, Glenn A., Reading, 214 Iowa, Oak Park
Baker, Dorothy M., Traverse City, 4119 N. Troy
Barak, Herbert G., Kalmazoo, 1528 Morse
Baron, Benzion C., Munising, Elmhurst
Barone, Chas. J., Detroit, Palmer House
Bauer, J. M., Ann Arbor, 11607 S. Bell Ave.
Bakst, Joseph A., Detroit, Stevens
Becker, Joseph William, Detroit, Stevens
Behen, Wm. C., Palmer House
Benjamin, Margaret F., Kalmazoo, Eastgate
Bergo, Howard L., Detroit
Bergman, M. S., Detroit
Bernstein, Albert E., Detroit, Stevens
Bernstein, Eli N., Flint, Morrison
Berwaud, Herbert T., Battle Creek, 5th Army Hqdrs.
Bethell, Frank H., Ann Arbor, Sherman
Bittrich, Norbert M., Detroit, LaSalle
Bloom, C. J., Muskegon
Botvinick, Isadore, Detroit, Palmer House
Braham, Wilbur G., Sturgis, Midland
Brand, Benjamin, Detroit, Chicagoan
Brook, J. D., Grand Rapids, Sherman
Brown, George Maxwell, Bay City, Stevens
Browning, Eugene S., Grand Rapids, Dalton
Brunson, Allen E., Sturgis, Sheraton
Buchman, Elwood, Dearborn, Whitehall
Burt, Charles W., Detroit, Drake
Buxton, Robert W., Ann Arbor, Palmer House
Campbell, Alexander M., Grand Rapids, Congress
Campbell, Lloyd A., Saginaw, Stevens
Cawley, Edward P., Ann Arbor, Stevens
Chandler, Donald, Grand Rapids, Morrison
Chester, William P., Detroit, Stevens
Christopher, James G., Detroit, Sherman
Coller, Frederick A., Michigan, Drake
Cosgrove, William J., Detroit, Palmer House
Cowen, Robert, Detroit, Drake
Conn, Jerome W., Ann Arbor, Palmer House
Croman, Joseph M., Jr., Mt. Clemens, Harrison
Cox, Ferdinand, Jackson, Union Park Hotel
Davis, William H., Grand Rapids, c/o Dr. J. R. Raper, University of Chicago

(Continued on Page 836)



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DeBeer, Guy W., Grand Rapids, Knickerbocker
Denholm, Nan Agnes, Flint, Sheraton
DeWeese, Marion S., Ann Arbor, Palmer House
Doub, Howard P., Detroit, Stevens
Donaldson, Sam W., Ann Arbor, Sheraton
Drinkaus, Harold, Detroit, 2915 110th Pl.
Dunlap, S. F., Detroit, East Chicago, Ind.
Dunn, F. Mansel, Lansing, Lake Shore Drive Hotel
Ellis, Claude I., Suttons Bay, Palmer House
Spurrier, Ethelbert, Detroit, Drake
Garrett, Evan L., Niles, Fort Dearborn
Falls, Harold F., Ann Arbor, LaSalle
Farbman, Aaron A., Detroit
Fath, August F., Kalamazoo, Stevens
Faunce, Sherman P., Detroit, Palmer House
Fenton, Russell F., Detroit, Union Park Hotel
Ferguson, Lynn A., Grand Rapids, LaSalle
Fill, Leon, Detroit, Sherman
Fordell, F. S., Detroit, Palmer House
Forrester, A. V., Detroit, Planters
Foucek, B. Charles, Three Oaks, Berwyn
Raisch, Frederick J., White Pigeon, 4847 Lake Park
Freund, Hugo A., Detroit, Ambassador East
Gertz, Michael A., Ironwood, Bismark
Gingold, S., Detroit
Goodhue, Lolita, Kalamazoo, Congress
Gudes, David S., Detroit, Croydon
Gutow, Julius J., Flint, Drake
Habenicht, Hilda A., Jackson, Crest
Hagele, Marie A., S. Ste. Marie, 120 Oak Park
Hague, R. F., Flint, Palmer House
Hansen, Frederick E., Detroit, Maryland
Harvey, A. B., Taylortown, Stevens
Hegener, A. J., Petosky, Sherman
Hendelman, M. H., Detroit, Chicagoan
Henderson, Leslie T., Grosse Pointe, Palmer House
Heneveld, John, Muskegon, Allerton
Hickey, Joseph, Detroit, Blackstone
Hirschman, Louis, Detroit, Stevens
Holmes, Roy H., Muskegon, Dearborn Plaza
Hodges, Fred Jenner, Ann Arbor, Palmer House
Hubbard, Myron F., Detroit, LaSalle
Huffman, Marquis R., Milford, Morrison
Hufford, A. Ray, Grand Rapids, Blackstone
Hurnett, Frank, Kansas City, Palmer House
Iacobell, Peter H., Detroit, Palmer House
Johnson, Kenneth H., Lansing, St. Charles
Jones, Tyre K., Marshall
Kallet, Herbert L., Detroit, Stevens
Kane, W. J., Mt. Clemens, Congress
Kanter, Frank J., Herman, Stevens
Katzman, I. S., Detroit, Chicagoan Hotel
Kerr, Howard J., Muskegon, Dearborn Plaza
Kokowicz, R. J., Detroit, Croydon
Kossayda, A. W., Detroit, Harrison
Laffoon, France L., Raytown, Morrison
Lentini, Joseph R., Grand Rapids, Knickerbocker
Liddicoat, Arthur G., Detroit, Stevens
Lilga, Harris V., Petoskey, Sherman
Lingaiah, Lalitha, Ann Arbor, Mayflower
Lipkin, Ezra, Detroit, 4940 East End Ave.
Lung, Earl C., Detroit, St. Clair
Lynn, Harvey D., Detroit, Drake
MacKenzie, O. R., Walled Lake, Palmer House
Malone, James G., Kalamazoo, Sherman
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Maynard, W. A., Coleman, Wedgewood
McDonald, James E., Battle Creek, 1240 S. 59th Court, Cicero
McGarvey, W. E., Jackson, Palmer House
McWilliams, Wm. B., Maple Rapids, New. Lawr.
Mendelssohn, Reuben J., Detroit, Chicagoan
Miller, J. D., Grand Rapids, Palmer House
Mills, Clinton C., Detroit, 5705 W. Ohio St.
Moisides, V. P., Detroit, 4540 N. Dover
Morrish, Ray S., Flint, Congress
Morrow, Robert J., Lansing, Stevens
Mosier, Edward C., Otisville, Brevoort
Mullenmeister, H. F., Battle Creek, 5805 S. Fairfield
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Myers, Dan W., Detroit, Knickerbocker
Nesbit, Reed M., Ann Arbor, Palmer House
Nesbitt, William E., Alpena, Palmer House
Neill, Edwin J., Detroit, Chicagoan
Nigro, Norman D., Detroit, Stevens
Oden, C., Muskegon
Palmer, Alice E., Detroit, Congress
Palmer, Hayden D., Pontiac, Shore Crest
Patmos, Martin, Kalamazoo, Piccadilly
Pearson, S. M., Bay City, Sherman
Peet, Max M., Ann Arbor, Palmer House
Peven, Philip S., Detroit, LaSalle
Pfeifer, A. C., Mt. Morris, Stevens
Pinkus, Hermann, Monroe, Sherman
Podolsky, Harold M., Dearborn, 926 E. 46th St.
Potter, Earl C., Lansing, Allerton
Praty, Lawrence A., Detroit, Congress
Price, Leonard, Muskegon, 719 Buena Ave.
Quinn, Edward L., Detroit, Stevens
Ratliff, Rigdon K., Ann Arbor, Sherman
Rice, Franklyn G., Niles, Brevoort
Robb, Herbert F., Belleville, Congress
Robinson, Harold C., Grand Rapids
Robinson, W. G., Hart
Rosenbaum, Herbert, Dearborn, Seneca
Rosbolt, Oscar P., Detroit, Stevens
Rupper, John H., Dearborn, 11025 S. Green St.
Rummell, Robert J., Fennville, Morrison
Saltonstall, G. B., Charlevoix, Stevens
Schaefer, Robert L., Detroit, LaSalle
Schiller, Arthur, Detroit, Palmer House
Salmon, Bertha L., Battle Creek, McCormick Y.
Saltzstein, Harry C., Detroit, Drake
Sands, George E., Detroit, Belair
Schnute, Louise F., Grand Rapids, 5540 Blackstone
Schraer, Paul H., Dearborn, Croydon
Schwartzberg, J. A., Detroit, Stevens
Scott, Robert D., Flint, Drake
Shaffer, Loren W., Detroit, Drake
Sidell, R. H., Grand Rapids, 455 May, Elmhurst
Sirhal, Alfred M., Brooklyn, West Side YMCA
Small, Henry, Detroit, Stevens
Smith, D. R., Iron Mountain, Hamilton
Smith, Robert B., Grand Rapids, 6225 Woodlawn
Sniderman, B. F., Flint, Stevens
Sorkin, Morris L., Flint, Croydon
Springborn, B. R., Detroit, Stevens
St. Arnuor, H. J., Detroit, St. Clair
Steiner, A. A., Lansing, Sherman
Stewart, Harry L., Jr., Detroit, Palmer House
St. Louis, R. V., River Rouge, Blackstone
Stokfisz, T., Detroit, Atlantic
Szappanyos, Bela, Detroit, Harrison
Tesseine, Arthur J., Grand Rapids, Knickerbocker
Trumble, G. W., Flint, Morrison
Turkel, Henry, Detroit, Palmer House
VanBree, Raymond S., Grand Rapids
Van Rhee, George, Detroit, Stevens
Van Sickle, Thomas E., Grand Rapids, Mira-Mar
Vardon, Colin C., Detroit, Harrison
Wacek, W. H., Ironwood, Atlantic
Walker, Roger V., Detroit, LaSalle
Watson, J. Edwin, Detroit, Stevens
Wells, Merrill, Grand Rapids, Stevens
Wenger, A. V., Grand Rapids, Sherman
Weyher, Russell F., Detroit, Morrison
Wilkinson, Chas. F., Ann Arbor, Palmer House
Wilson, Walter J., Jr., Detroit, Sherman
Whittaker, A. H., Detroit
Wittenberg, Sydney S., Detroit, Palmer House
Wreggit, W. R., Highland Park, Lincoln Park Arms
Zabinski, E. J., Detroit

Wednesday, June 23

Alexander, W. H., Iron Mountain, Union League Club
Andrews, Sherman E., Kalamazoo, Stevens
Buchanan, W. F., Fenton
Bachman, Morris E., Detroit
Baird, W. Claire, Flint, Drake
Banting, O. F., Richmond, Midland
Barris, Ralph W., Grand Rapids, Stevens
Beers, C. W., Muskegon Heights, Parkway
Bliesmer, A. F., St. Joseph, Union League Club
Boys, Charles E., Kalamazoo, Knickerbocker
Brady, M. J., St. Clair, Bellair
Britton, George Thos., Marcellus
Brotherhood, James S., E. Grand Rapids, Palmer House
Brown, A. O., Detroit, Stevens
Brown, F. W., Jr., Lansing, Hamilton
Budson, Daniel, Detroit
Cameron, H. K., Saginaw
Campbell, Darrell A., Eloise, Stevens
Cantor, Meyer O., Detroit, Drake
Carnes, Harry E., Detroit, Drake
Carp, Joseph, Detroit, Sherman
Clapp, Henry W., Muskegon, St. Clair
Cooper, J. Elbert, Battle Creek, Stevens
Copeland, Evan L., Decatur
Corkill, C. C., Douglas, 2130 Lincoln Parkway
Coultier, Wm. J., Detroit, Sheraton
Cowan, John A., Lansing, Knickerbocker
Croll, L. J., Detroit, Palmer House
Cummings, H. H., Ann Arbor, Palmer House
DeJong, Russell N., Ann Arbor
Donald, Douglas, Detroit, Palmer House
Ducey, Edward F., Grand Rapids, 1507 Arthur
Dwyer, Harold V., Detroit, Stevens
Elliott, Hardie B., Flint, Harrison
Fancher, Paul S., Battle Creek
Fenton, Meryl M., Detroit, Ambassador East
Fenton, Stanley C., Detroit, St. Nicholas
Fillingham, Enid, Muskegon, 4910 N. California
Foshee, J. P., Grand Rapids, Palmer House
Friedlaender, Alex S., Detroit, Allerton
Friedlaender, Sidney, Detroit, Allerton
Friesleben, William, Sauk Rapids, Aurora
Gilfillan, Margery T., Battle Creek, South Shore Country Club
Gamble, W. G., Jr., Bay City, Morrison
Geronimo, Marano S., Capt., Battle Creek
Glasgow, Gordon K., Detroit, Hamilton

(Continued on Page 838)

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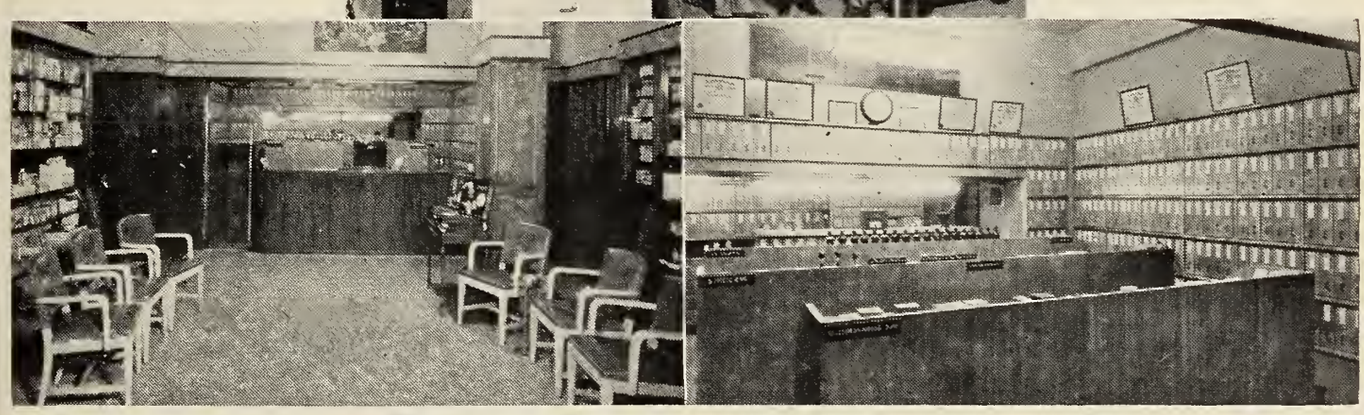






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Hagman, Geo. L., Bloomfield Hills, Mark Twain
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Herkimer, Dan R., Lincoln Park, Stevens
Kahn, David, Lansing, Blackstone
Keene, Clifford H., Ann Harbor, Stevens
Kelly, Edward F., Grand Rapids, 220 E. Pearson
Kilmer, David N., Reed City, Hamilton
Kirschbaum, Harry M., Detroit, Congress
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Kromer, Robert, Wayland, 6527 Kimbark
Kpupp, C. G., Grand Rapids, Harrison
Lang, L. W., Detroit, Hamilton
Laurin, U. S., Muskegon, Knickerbocker
Limbach, David R., Flint, Harrison
Loupee, George E., Dowagiac
Lowrie, William L., Detroit, Sherman
Martin, E. G., Detroit, Stevens
Mayer, Willard D., Detroit, Palmer House
McElmuny, Leland R., Lansing, Stevens
McNeill, Howard H., Pontiac, Stevens
Miller, Phillip L., Muskegon
Morford, Fred N., Muskegon
Morris, Harold, Detroit, Harrison
Nelson, Lorenzo R., Baldwin, 4734 E. Parkway
O'Boyle, Cyril P., Alpen, Palmer House
O'Brien, G. M., Detroit
Pierce, Kenneth C., Dowagiac
Polentz, Charles Paul, Detroit, Drake
Pollard, H. Marvin, Ann Arbor, Drake
Porretta, F. S., Detroit, Morrison
Pyle, Henry J., Muskegon
Reed, H. Walter, Detroit, Harrison
Reus, Wm. F., Grand Rapids, Harrison
Rice, Meshel, Detroit, Eastgate
Richmond, Dean M., St. Joseph
Reagan, Robert E., Benton Harbor, Allerton
Roland, Charles F., Detroit, Stevens
Rom, Jack, Detroit, St. Clair
Root, Samuel W., Ann Arbor, Great Lakes
Ruedeman, Albert D., Detroit, Palmer House
Ruskin, Dave B., Caro, Washington
Ryan, Charles F., Detroit
Ryan, William D., Detroit
Sandweiss, David J., Detroit, Drake
Sayre, Philip P., Onsted, Crest
Schnoor, Elmer W., Grand Rapids, Lake Shore Club
Schulte, Carl H., Detroit, Edgewater Beach
Scott, Dwight, Sault Ste. Marie, Hinsdale
Sevensma, E. S., Grand Rapids, Bismarck
Shafer, Harold C., Bay City, Stevens
Sheldon, John M., Ann Arbor, Palmer House
Smith, R. Earle, Grand Rapids, Hamilton
Smith, W. Joe, Cadillac, Palmer House
Sofen, M. B., Kalamazoo, Chicagoan
Strick, Marvin H., Benton Harbor
Stryker, Walter A., Grosse Ile, Allerton
Sutherland, J. M., Detroit
Sutton, Palmer Evans, Royal Oak, Palmer House
Szilagyi, D. Emerick, Detroit, Lake Shore Drive Hotel
Taylor, Ivan B., Detroit, 5120 Bernice
Teifer, Charles A., Muskegon, Congress
Walls, Arch, Detroit, Sheraton
Wendel, J. S., Detroit
Wiener, Israel, Detroit

Thursday, June 24

Alcorn, Marshall W., Bay City, 1712 N. Park
Alexander, Reuben G., Lansing, Chelsea
Bergsma, Stuart, Grand Rapids
Black, Charles E., Williamston
Black, Gertrude C., Williamston
Boccia, James J., Detroit
Bodine, Harold R., Battle Creek, Morrison
Boersma, Donald, Grand Rapids, 10640 Eggleston
Bryce, John D., Detroit, Harrison
Buchanan, William Paul, Detroit, Harrison
Burbidge, Earl L., Kalamazoo, Hamilton
Clark, Ronald E., Detroit, Palmer House
Corbils, Burton R., Grand Rapids
Croushore, James E., Detroit, Ambassador West
Curhamm, Joseph H., Detroit, LaSalle
Currier, Fred P., Grand Rapids, Drake
Curry, Fillmore S., Detroit
Cusick, Paul L., Detroit, Drake
Deneen, Owen, Detroit, Palmer House
Douglas, Bruce H., Detroit
Dowdle, Edward, Detroit, Palmer House
Drews, Robert S., Detroit, Congress
Droste, James C., Grand Rapids, 1234 S. Wabash
Fenning, Foster A., Marquette, Palmer House
Fiegel, S. Albert, Sturgis, Blackstone
Finkelstein, M. B., Detroit, Sherman
Green, W. L., Kalamazoo, Stevens
Griffith, Lucian S., Grand Rapids
Hall, James W., Traverse City, 6945 Oglesby
Hershey, Noel J., Niles, Shoreland
Humphrey, Arthur A., Battle Creek, Ambassador East
Hyland, William A., Grand Rapids, Drake
Johnson, Homer L., Detroit, Sherman
Johnson, Orlen J., Bay City
Jones, Robert R., Battle Creek, West Side YMCA
Kasabach, Harry Y., Detroit, Palmer House
Kay, Ceceilia S., Muskegon, 3615 N. Wilton
Kennary, James M., Detroit, Morrison
Klein, J. Paul, Fremont, Palmer House
Kouda, Jennings C., Battle Creek
Krass, Edward W., Detroit, Palmer House
Lecklider, Arlington F., Detroit, Stevens
Lodmell, Elmer H., Battle Creek
Lohr, Oliver W., Saginaw
Mackersie, W. G., Detroit, Hamilton
Markoe, Rupert C. L., Detroit
Marshall, Don, Kalamazoo
Mazur, Treodore T., Battle Creek
Meister, Franklin O., Battle Creek, Stevens
Medema, Paul E., Muskegon, Hamilton
Monto, Raymond W., Detroit, Dearborn
Mykytew, Marion, Detroit, Harrison
Northouse, P. B., Grand Rapids, Shore Crest
Ormond, John K., Detroit, Palmer House
Payne, C. Allen, Grand Rapids
Meyers, H. Marjorie Peebles, Detroit, 4356 Calumet
Peelen, Matthew, Kalamazoo, Morrison
Piekker, J. D., Grand Rapids
Rennell, Leo P., Detroit, Palmer House
Reveno, William S., Detroit
Rowe, R. E., Manistee
Rylander, Carl M., Battle Creek
Schaftenaar, R. H., Holland, Morrison
Schmidt, Harry E., Detroit, Stevens
Scott, William J., Grosse Pointe Farms, Stevens
Shafarman, E. M., Detroit, Harrison
Sheldon, John P., Sturgis, Blackstone
Shellman, M. W., Grand Rapids
Siegfried, E. G., New Haven, 1804 W. Congress
Sisson, John M., Detroit, Harrison
Slagh, Earl M., Elsie, Morrison
Slagle, George W., Battle Creek, Ambassador East
Sobel, Robert A., Detroit, Sherman
Swanson, H. C., Grand Rapids, 7753 N. Haskins
Thompson, A. A., Mount Clemens, Sherman
Upjohn, E. Gifford, Kalamazoo, Hamilton
Vander Laan, John E., Muskegon, 6759 Bennett
Vannest, Alfred E., Detroit, Stevens
Venier, Joseph Henry, Lansing, Sherman
Vroon, John, Grand Rapids
Whalen, Neil J., Detroit, Palmer House
White, Arthur E., Battle Creek
Wietersen, Fred K., Birmingham, Palmer House
Wiley, D. Bruce, Utica, 1804 W. Congress
Willoughby, Gordon L., Flint, Stevens

Friday, June 25

Addison, Earl R., Crystal Falls, Palmer House
Allen, Robert L., Battle Creek, 319 S. Central Park
Altland, J. K., Lansing, Knickerbocker
Blaha, Vernon B., Detroit, Drake
Bradshaw, Park S., Sherman
Brough, Glen A., Detroit, Knickerbocker
Brunson, E. T., Ganges, Harrison Hotel
Byrd, Mary Lou, Grand Rapids
Carpenter, Luther C., Jr., Grand Rapids, Palmer House
Chittenden, George E., Detroit, Stevens
Claytor, Robert W., Grand Rapids, Palmer House
Cooksey, Warren B., Detroit
Connelly, Richard Campbell, Detroit
Conrad, Maynard M., Kalamazoo
Cotton, Schuyler Opp, Detroit, LaSalle
Crane, W. B., Kalamazoo, Palmer House
Fahlund, George T. R., Grand Rapids, Palmer House
Fattie, G. R., Jr., Niles
Garber, Frank W., Muskegon
Goss, Samuel B., Detroit, 751 S. Lawndale
Hauser, I. Jerome, Detroit, Edgewater
Heneveld, Edw. H., Muskegon, Allerton
Hibbs, Donald K., Battle Creek
Hollands, R. A., Battle Creek, Rolling Prairie, Indiana
Hubell, R. J., Kalamazoo
Kilmer, Paul B. Reed City
Knoll, Leo A., Ann Arbor
Kuhn, Albert A., Detroit
Kulcman, Harold J. Dearborn
Lauting, Helen, E. Lansing
Lauting, R., Lansing, 620 Stanton, Whiting, Ind.
Lewis, Elmore F., Jackson, St. Clair
MacGregor, M. W., Detroit
McNabb, Arthur A., Watervliet
Mark, Jerome, Detroit
Meyers, Lewis, Kalamazoo, Eastgate Hotel

(Continued on Page 868)

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Elimination of Abdominal Sinuses and Fistulas

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ONE OF THE most distressing complications of surgery is a persistent abdominal sinus or fistula. This may dislocate the patient's normal routine, require many hours of special attention, inflict an inferiority complex or prove objectionable to those with whom he associates, and handicap the possessor for many pursuits of life.

With a discharging abdominal opening, one should first determine whether it is a sinus or a fistula—usually easily shown by injecting a bland, sterile solution into the opening. With a sinus, comparatively little fluid can be injected, and this little tends to flow out as soon as the syringe is removed. With a fistula, fluid enters without resistance and does not return. If the fluid is colored, as by methylene blue, a prompt expulsion of bluish water from the bowel suggests a colonic fistula; a delayed bluish dejection, a higher intestinal fistula; while the vomiting of the colored fluid or its immediate withdrawal by gastric or duodenal tube may occur with a gastric, duodenal or biliary fistula. Again, the immediate passage of bluish urine is characteristic of a fistula of the urinary tract. The type of pain produced by the injection also may aid in the diagnosis if it has the characteristics of an intestinal, gastric, biliary, vesical, renal or ureteral colic. More accurate information, of course, is to be obtained by roentgen examination after filling a sinus with bismuth paste, or the injection of a fistula with air or a radiopaque liquid. Of course, one would not inject an insoluble material, such as a barium mixture, into what might prove to be a biliary or urinary fistula.

Sinuses are more common after abdominal operations than fistulas, and usually are due to a foreign body, such as a ligature or suture, or to a tortuous channel that prevents free drainage. Not infrequently a chronic sinus is due to improper treatment, such as the repeated introduction of gauze, which obstructs drainage. If due to a foreign body this should be located by a probe or small crochet hook, or by enlarging the opening, and should be removed. A poorly draining sinus tract should be treated by a plomb. One of the best consists of 25 to 50 per cent bismuth subiodide in petrolatum. A 2 c.c. glass Luer syringe is packed with the mixture; the tract is wiped out with cotton applicators wet with tincture of iodine, and then is distended by injecting the plomb. The plomb does not prevent drainage, and as it is slowly expelled the sinus closes from the bottom. After a week it may be necessary to renew some of the plomb that has been extruded.

Small fistulas occasionally heal if the edges are stimulated by application of tincture of iodine and covered, not injected, with a protecting layer of the bismuth paste, but most fistulas require operative closure.

In an abdominal operation the gastrointestinal tract may accidentally be damaged, or an area weakened by inflammation or malignant process may give way, with a resulting fistula. Such postoperative fistulas result in contaminated and sup-

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purating wounds, and it has been thought that the opening should not be closed until, after weeks or months, all necrotic tissue has separated and the area is covered by firm healthy granulations. We have learned, however, that in the early inflammatory stage it is often possible to close a gastric or intestinal fistula if the adjacent edges can be freed sufficiently to relieve tension and then be inverted, and the opening closed with fine stainless steel wire sutures. Silver wire is too fragile, and the failures of the past were largely due to the catgut, silk or cotton sutures used. Usually 35 gauge stainless steel wire sutures, the ends of which are tied in a square knot, are satisfactory; but with a large laceration of the stomach and the patient *in extremis* from the loss of fluid and metabolites, the 35 wire sutures broke under peristaltic tension. Recovery without leakage followed the use of 32 gauge sutures.

The great value of metallic sutures in the closure of fistulas, first demonstrated by J. Marion Sims nearly 100 years ago, and since almost forgotten, also is illustrated in the case of a boy of eighteen, who developed symptoms of acute intestinal obstruction and was treated by a Miller-Abbott tube for two weeks. The tube passed through the colon, but the patient was dissatisfied and transferred to a second hospital, where a large appendiceal abscess was discovered and drained. Then the obstruction recurred; a cecostomy was done, which two weeks later was followed by prolapse of the cecum, cecal fistula, and an ileus for which a jejunostomy was done. After eighteen months of palliative treatment in and out of a hospital, intense irritation of the skin, ileocecal prolapse, incisural hernia and fistulas were present. In such a case the fistulas should not be expected to close spontaneously. Without opening the abdomen, a slight liberation of jejunum about the fistula was first made, and the edges inverted with interrupted fine stainless steel wire sutures. A week later the opening in the cecum was closed, the bowel replaced in the abdomen, and in ten days the tissues were in condition for repair of the abdominal hernia. A complete restoration, due to an all-wire technique followed.

Similar fistulas may result from a strangulated hernia, a gunshot wound or other abdominal injury. In removal of the right kidney the wall of the duodenum has accidentally been included in the ligation of the renal pedicle, with a resultant very troublesome, duodenal fistula, formerly considered incurable. Also, in removal of the left kidney, the sigmoid or descending colon may be damaged, with very troublesome fistulous formation. In operating for all such fistulas, only nonirritating wire should be used for both sutures and ligatures, as then results may be obtained not possible with the conventional suture materials.

When a patient, after a difficult delivery or an abdominal or vaginal hysterectomy, develops a persistent watery vaginal discharge, we expect to find a vesicovaginal fistula. If, however, the watery vaginal discharge causes an extensive excoriation of the skin, it usually indicates a small intestinal fistula. The discharge is thinner, less offensive, but much more irritating than that from the large bowel.

In one case the discharge had followed a vaginal hysterectomy performed with clamps, and week after week the patient had been urged to delay until the discharge ceased spontanously. But a small entero-vaginal fistula requires operative closure. In this case the side of a loop of intestine had been pinched in the hysterectomy clamp. Rarely is it feasible to close the opening from below; an abdominal incision is desirable, and the closure is a simple procedure.

In another patient there was an even more intense perineal irritation, an extensive laceration of small intestine having occurred in the removal of a cancer of the rectosigmoid. Several unsuccessful attempts had been made to close the fistulous opening through the perineum, and the patient was referred for transabdominal repair. In the abdominal correction several disconnected segments of adherent small intestine were removed, and an end-to-end anastomosis performed. Following this operation a watery vaginal discharge continued, due to an overlooked divided left ureter, which then was implanted into the bladder. Months later, an intermittent, clear, odorless, nonirritating, thin, watery discharge occurred through a pinhole opening in the vaginal vault, which proved to be due to another small disconnected segment of small bowel adherent to the outer vaginal wall. Relief followed the removal of this adherent segment of intestine.

Surgeons who present a model patient to show the convenience and desirability of a colostomy in operating for cancer of the rectum do not mention the large percentage who find it an unpleasant and time-consuming burden or even beyond endurance. I have now transferred to the perineum or other-

wise eliminated over sixty abdominal colostomies. After being transferred to the perineum, a troublesome colostomy has been found much more manageable, even though the sphincter muscles have been removed.

For example, Dr. S., after a Miles operation, was unable to control the escape of offensive gas when he bent over to examine a patient, although he irrigated the colon several times a day. He contemplated suicide, and traveled from surgeon to surgeon to find one willing to move the colostomy to the perineum. I was glad to try the experiment for him, and he left the hospital, healed, eleven days after the colostomy was transferred. With the perineal opening, offensive gas was no longer troublesome. With an enema every second or third day he then could go without a protecting pad.

Miss H., after resection of a cancerous bowel with abdominal colostomy, lost her position in a bank from the odorous gas discharge. After transference of the colostomy to the perineum, the flatus was no longer noticed and it was possible to resume her position.

Mr. M., after a Miles operation, had an uncontrollable abdominal colostomy that gave constant trouble. Ten months later I moved the colostomy to the perineum. The patient now has a warning of an approaching defecation and finds a protective pad unnecessary.

A prolapse of the bowel, with or without abdominal hernia, may be particularly troublesome, as in the case of Mr. B., who had developed very large protrusion of the bowel, requiring hours of attention daily, eleven years after a Miles operation. Despite a limited recurrence of the gelatinoid carcinoma in the pelvic floor, the bowel was resected and the colostomy brought through the perineum, and the associated abdominal hernia corrected. After the operation there was no involuntary leakage from the perineal colostomy, and the patient lived seven years after the operation in relative comfort.

Following a Mikulicz operation for carcinoma, wound complications may render the closure of the intestinal opening difficult. One patient weighed 300 pounds and had an eventration after a Mikulicz resection of her transverse colon, for which a fascial graft failed. She remained in bed one year. After closure of the enormous fistula and hernia with bowel resection, performed with stainless steel wire, there was primary union.

Occasionally a colostomy is done for diverticulitis or other benign condition in the belief that an ineradicable carcinoma is present. Mr. C., aged sixty-two, had intestinal obstruction. At operation a large mass, diagnosed as cancer, was found in the sigmoid adherent to the left iliac vessels and the small bowel, and a colostomy was performed. On our exploration in an attempt to eliminate the colostomy, it was discovered that the mass was due to a perforated diverticulitis. The involved large and small loops of bowel were liberated and resected with end-to-end anastomosis, eliminating the double-barreled colostomy.

When a colostomy has been made close to the pelvic colon, a satisfactory solution may result from removing the lower segment and bringing the colostomy through the split anal ring or perineal scar. Mr. L., a clergyman, aged fifty-six, was very largely incapacitated by a colostomy for diverticulitis in 1943. A "pull-through" operation eliminated the diseased segment and the colostomy and restored the anal function.

Since 1930 I have avoided a permanent colostomy for obstructive and ineradicable carcinoma of the bowel. The colostomy may incapacitate the patient and make him a disgusting burden upon the hospital or his friends until his death. If the surgeon can remove the primary obstructing tumor with an end-to-end or "pull-through" type of operation, the patient usually will be markedly improved and may continue to be active for some months or years. One of our elderly patients who had multiple secondary growths in the liver lived in relative comfort for nine years after the primary growth was removed, with end-to-end anastomosis, and a number have lived two or three years.

Dr. R., aged forty-two, had a carcinoma of the sigmoid adherent to the iliac vessels, with metastases in the liver and peritoneum. A palliative colostomy had rendered him unable to practice for seven months. After we had eliminated the colostomy by a resection and end-to-end anastomosis, he was able to resume practice for seven more months before the terminal stage arrived.

I have performed radical resection without colostomy in over 100 cases of carcinoma of the large bowel with ineradicable extension. The mental and physical improvement and relief from pain is usually well worth while and is quite in contrast with the mental depression and physical burden attending a palliative colostomy. For a patient

in the terminal stage no operation is advised, but a low residue diet, glycerin by mouth and sufficient opiates to relieve pain are used.

The Mikulicz operation for carcinoma of the bowel, in which the loop of diseased bowel is exteriorized above the abdominal wall and then cut away, requires retention of so much bowel, with adjacent lymphatics, for the final closure that frequently the operator fails to remove all malignant tissue, and recurrence follows. Minor objections are the multiple operations and length of time consumed in the final closure of the colostomies, and the abdominal hernia which often results. We therefore try to avoid this operation. There are many examples of the fatal recurrences in the abdominal wall and lymphatics that follow this operation, but for which the patient might have been cured of the cancer.

Heavy x-ray irradiation over the intestinal tract may lead to bowel obstruction as long as seven years after the roentgen treatment. The condition may be relieved by excising the scarred bowel, with end-to-end anastomosis, but the usual treatment is colostomy. Such a patient, aged twenty-five, who had a cancer of the uterus treated by x-rays, did not wish to be married while she still had the colostomy. Transplantation of the colostomy through the split anal ring gave an excellent functional result, and was followed by a honeymoon and period of relief before this growth recurred.

A very troublesome abdominal fistula may follow appendicitis. Mrs. C., wife of a physician, had three operations to close such a fistula, including side-to-side ileotransversostomy. Such operations for eliminating a section of intestine are often advised, and often add a new complication, as in this case, the addition of small intestinal contents to the discharge, with greatly increased local irritation. The curative treatment here was to excise the eliminated section, with end-to-end anastomosis of ileum to the transverse colon.

Again, prolonged invalidism may still follow a retained and undiagnosed diseased appendix. One patient, at eighteen, had had an operation for appendicitis but the surgeon did not tell her that he had failed to find the appendix. At forty she was a confirmed invalid, taking morphine for pain, and had had five abdominal operations. She had been confined in a hospital for a year, first for a supposed intestinal malignancy and then for an "ineradicable enteritis," and had been left with fistulas of the small and large intestine. By carefully following the planes of dense adhesions, the cause of the trouble was found in a discharging appendix high under the right kidney. Removal of the appendix and eradication of the fistulas resulted in complete rehabilitation.

A rare cause of colostomy is the perforation of the colon by a curet or other instrument in the performance of an abortion. With one woman of forty-three years, the colostomy had been performed eighteen years earlier for that reason.

In infancy an abdominal fistula or colostomy is used for a high type of imperforate anus. In one patient the rectum terminated in the bladder, and a double-barreled colostomy had been performed but the operator had not separated the proximal from the distal opening, and fecal material ran over into the bladder. Therefore it was necessary to separate the two openings. As the child grew older the terminal rectum was disconnected from the bladder, the opening in the bladder closed and the rectum brought through the perineum. Finally the colostomized bowel was reunited and the abdomen closed.

After infancy, a megacolon, or Hirschsprung's disease, comes under treatment. The removal of sympathetic ganglia, formerly advised, has proved unsatisfactory. In a girl, a congenital stricture of the rectum was found; a cecostomy had been performed at eighteen months. At six years the cecostomy had been closed. At twelve years a transversostomy was performed. At thirteen years we pulled the enlarged rectosigmoid through the split anus and amputated it, with very good functional result.

The colored woman who has had a colostomy for lymphopathia venereum is in a deplorable condition. Even with the present demand for domestic help, no one will hire her as a cook, waitress or even laundress. In several such cases we have excised the ulcerated and densely cicatrized rectum and pulled through the split sphincters a healthy segment of sigmoid, for a functional perineal outlet is not a bar to employment.

To illustrate the technique of colostomy transplantation, let me mention a woman with an adherent cancer of the rectum, for whom two attempts at extirpation were abandoned on account of adhesions, and a colostomy was performed. The patient threatened suicide if left with the colostomy, so the colostomy was freed, covered by a rubber cup and the rectosigmoid liberated through the

abdomen. The loop of rectosigmoid, with the carcinoma and colostomy, were then delivered through a perineal incision and a perineal anus was formed which proved satisfactory to the patient.

For odorous wounds and fistulas, copious dressings of gauze wet with 1:500 to 1:1000 solution of bromine will neutralize the fetor and stimulate granulations.

After operation on the biliary tract a biliary or mucupurulent fistula may develop and be difficult to close. If the gall bladder has been drained but not removed and there is a mucopurulent fistula without bile, an unremoved stone impacted in the neck of the gall bladder is to be suspected, which will persist until the stone is removed. In a few instances and with a sufficiently large opening, I have been able to expose the stone through an open cystoscope, and partially dissolve it by applying cotton swabs saturated with ether until the impacted stone could be dislodged or fragmented and removed. With removal of the obstruction, a gall-bladder fistula usually will close spontaneously, but as a rule the better plan is to delineate the fistula by injecting a solution of methylene blue and then to remove the abdominal scar and fistulous tract, gall bladder and contained stone *en masse*. After tube drainage of the common duct, which at present we have largely abandoned, a persistent biliary fistula may annoy the patient. By inserting a small catheter into the fistula, to which continuous aspiration is applied, the walls of the tract may be forced together and the fistula closed, in many cases in from one to four days. In recent years I have sutured but not drained the common duct, the peritoneum being protected from leakage by a sump drain, which has greatly shortened the convalescence and eliminated these secondary fistulas.

Summary

With improvements in operative technique, the field of colostomy has been rapidly reduced. It should become a rare operation except as a palliative measure. Perineal colostomy has been developed into a very satisfactory replacement operation for the abdominal opening.

The use of colostomy as a terminal operation for advanced carcinoma of the bowel has produced more distress than benefit, and should largely be restricted.

Ileostomy, used particularly for intense forms

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Cardiac Emergencies

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ALTHOUGH heart diseases are usually chronic progressive ailments, very acute, dramatic, and alarming episodes may occasionally occur in their course, requiring the rapid institution of proper treatment in order to prevent the death of the patient. Since these cardiac emergencies are common, and every practicing physician usually encounters several such instances each year, it is wise occasionally to review our knowledge regarding the diagnosis and management of these episodes.

Any factor which impairs the mechanical efficiency of the heart as a pump is capable of causing discomfort or death. Intrinsic myocardial damage resulting from anoxemia, inflammatory processes, scarring, or edema may decrease the amount of work the heart is capable of doing and lead to heart failure. Interference with the dynamics of blood flow by valvular deformities or extrinsic processes (e.g., compression of the heart by pericardial effusion, adhesive pericarditis, mediastinal emphysema, or tumors) may produce similar results. Non-organic cardiac aberrations such as changes in rate or rhythm, if sufficiently prolonged, may cause failure. Usually these factors produce heart failure only after they have been acting over a long period of time; however, myocardial anoxemia, compression of the heart, and changes in rate and rhythm may precipitate rapidly progressive disability, and constitute the commonest cardiac emergencies which require prompt recognition and treatment. We shall limit our discussion to acute compression of the heart, arrhythmias, myocardial infarction, and acute pulmonary edema.

Acute Compression of the Heart

Acute cardiac compression (cardiac tamponade) develops when the relatively inelastic pericardial sac becomes greatly distended by a rapid accumulation of fluid, such as may follow stab or bullet wounds of the heart, intrapericardial rupture of aneurysms, and suppurative or serofibrinous pericarditis. The increased intrapericardial pressure

Modified from a presentation at a staff meeting of the U. S. Marine Hospital, Galveston, Texas.

hampers return of blood via the venæ cava with resultant decrease in cardiac output and arterial pressure, and increase in venous pressure. The neck veins become engorged, pulsus paradoxicus (inspiratory collapse of the pulse) may appear, cyanosis and orthopnea develop, and the liver enlarges. The area of cardiac dullness increases, the heart sounds become fainter, and friction rubs, if previously present, usually diminish in intensity or disappear. Compression of the base of the left lung by the distended pericardium may cause dullness and bronchial breathing under the angle of the scapula (Ewart's sign), especially in children.

Roentgenologically, with moderate to large effusions, the cardiac shadow becomes enlarged and pear-shaped, with obliteration of the usual chamber contours; the cardiodiaphragmatic angles become more acute, and the amplitude of cardiac pulsations diminishes. Electrocardiograms may reveal low voltage and the characteristic ST segment and T wave changes of pericarditis.

Sudden death is not uncommon in these instances and results when the venæ cava collapse and the circulation ceases. It is of the greatest importance to determine the blood pressure at frequent intervals in these patients, because a falling pressure is a sign of danger and indicates the necessity for prompt aspiration of the fluid.

Pericardiocentesis is a relatively simple procedure. Three methods of approach are in common use: the precordial, the epigastric, and the posterior. For the precordial approach, the patient is seated with his back supported by a chair or the raised bed. The site of entry is in the fifth or sixth intercostal space about one inch mesial to the left border of cardiac dullness. After sterilization of the skin and infiltration of the skin and subcutaneum at the puncture site with 1 per cent procaine, a 16 to 20 gauge needle about 4 inches long with a fairly dull point, attached to a 50 to 100 c.c. syringe, is inserted and directed medially, upward, and backward, pointing toward the left hilus. Usually it is necessary to force the needle in only about 3 or 4 cm., depending on the thickness of the chest wall. If gentleness and caution are observed, the procedure is usually not dangerous. The transmitted cardiac pulsations can be felt through the needle if the heart is touched. Any interspace between the third and seventh may be used, provided that the puncture site is either lateral or mesial to the internal mammary vessels. The major dangers lie in the possibility of puncture of the coronary vessels, the heart wall (particularly the right auricle or ventricle) or the mammary vessels. Puncture of the pleura should be avoided because of the danger of pleural infection in cases of septic pericarditis. In such cases it is advisable to use the sixth interspace close to the sternum as the puncture site, or the epigastric approach.

In using the epigastric approach, it is advisable to have the patient reclining in bed with the head of the bed moderately elevated. The needle is inserted at the tip of the angle between the left costal margin and the ziphoid, and is directed upward, backward and toward the left, pointing toward the left scapula.

In children with characteristic signs of left lower lobe compression, the posterior approach is of value. With the patient's left arm raised, the needle is inserted in the seventh, eighth, or ninth interspace in the left midscapular line.

If the first puncture fails to reveal fluid, the direction and depth of the needle should be altered. If pus is encountered, pericardiotomy is indicated if the response to chemotherapy is not complete.

Following pericardiocentesis, the blood pressure and pulse rate should be watched carefully for six to twelve hours because of the possibility of injury to the right auricle or a coronary artery.

Effusions which may accompany rheumatic pericarditis usually resorb within a few weeks and rarely require tapping.

Acute Disturbances of Cardiac Rhythm

The sudden onset of an arrhythmia may lead to a decrease in cardiac efficiency with resultant precordial discomfort or pain, respiratory difficulties, and cerebral anoxemia (manifested by dizziness, headache, and possibly syncope). The arrhythmias are due to changes in irritability or conductivity of the myocardium or specialized conducting tissues. The most common arrhythmias are sinus arrhythmia, premature contractions, sinus tachycardia, and sinus bradycardia, but these have no acute significance ordinarily.

An ectopic rhythm should be suspected clinically when there is irregularity of the heart beat, or where there is a regular rhythm with a rate of less than 50 or more than 130 beats per minute,

particularly if there is a history of sudden onset of the rapid rate or if carotid sinus pressure produces abrupt halving of the ventricular rate. Other features suggestive of arrhythmias are variations in the intensity of the first heart sounds, and failure of the rate to vary with changes in posture, with exercise, or after the inhalation of amyl nitrite.

Although electrocardiographic corroboration may be necessary for the definitive diagnosis, the mechanisms responsible for most arrhythmias can be determined at the bedside. In the evaluation of any arrhythmia, detailed attention should be given to the following specific points:

1. Mode of onset and cessation (sudden or gradual), and character and duration of previous attacks, if any.
2. History of administration of digitalis, quinidine, thyroid, intravenous aminophylline, or other drugs affecting the heart.
3. Presence or absence of underlying organic heart disease.
4. Exact timing of the rate, and determination of the presence or absence of irregularity.
5. Effect of exercise, change in posture, or inhalation of amyl nitrite on the heart rate (provided, of course, the condition of the patient permits).
6. Character of the heart sounds (variations in intensity or quality).
7. Pulsations in the jugular veins as evidence of auricular activity.
8. Effect of carotid sinus pressure on the heart rate.

A brief review of the differential diagnostic features of the important arrhythmias may be pertinent.

A regular ventricular rate below 50 per minute may be due to sinus bradycardia, auriculoventricular block (complete, or partial with 2:1 block), or rarely to A-V nodal rhythm. In complete heart block (unless auricular fibrillation is also present), the occasional coincidence of auricular and ventricular contractions may cause variations in the intensity or quality of the heart sounds and the auricular contraction itself may be faintly audible as an extra sound, while in partial A-V block or in the other causes of a slow rate with regular rhythm, the heart sounds ordinarily do not vary from beat to beat. The jugular pulsations will be normal but slow in sinus bradycardia, may show very prominent vigorous pulsations in A-V nodal rhythm due to coincidence of auricular and ventricular contractions, will exhibit complete dissociation of the auricular and ventricular components in complete A-V block, and will show two auricular waves to each ventricular phase in 2:1 partial A-V block. Postural change, exercise, or the inhalation of amyl nitrite will cause a gradual increase in rate if sinus bradycardia is present, may cause a very slight acceleration in rate in complete A-V block, may accelerate or suddenly double the rate in 2:1 A-V block or may cause irregularity in the rhythm due to the substitution of a block of lesser degree with irregularly dropped ventricular beats. Instances of A-V nodal rhythm may return to normal sinus rhythm after exercise as a result of sympathetic stimulation. Sinus bradycardia and transient A-V nodal rhythm are generally benign conditions, usually not associated with heart disease, and ordinarily do not require treatment; they are important primarily because they must be differentiated from A-V block. Occasionally, A-V nodal rhythm is seen following depression of the sinus node by excessive doses of digitalis or quinidine, acute infection, or localized myocardial damage. Atropine or ephedrine may be used to accelerate the heart if it is felt that symptoms are due to the relatively slow rate of nodal rhythm.

A regular ventricular rate between 50 and 120 or 130 per minute is usually of normal sinus origin, but several exceptions must be mentioned such as nodal tachycardia, auricular flutter with persistent high-grade block, and the infrequent instances of complete A-V block with a relatively rapid idioventricular rate such as may occur occasionally with digitalis overdosage. A-V nodal tachycardia is rare and cannot be differentiated without electrocardiograms, but it may be suspected if the jugular pulsations are unusually vigorous due to coincidence of auricular and ventricular contractions as noted above. Carotid sinus pressure may increase the block in auricular flutter and cause abrupt slowing of the ventricular rate, with return to the original rate on cessation of pressure.

A ventricular rate of more than 130 per minute with a regular rhythm may be due to sinus tachycardia, paroxysmal auricular or ventricular tachycardia, or auricular flutter. The onset and cessation are generally abrupt in all of these except sinus tachycardia. Occasionally, a period of sinus tachycardia may follow ectopic rhythms and thus clinically simulate gradual cessation of the attack. Auricular fibrillation may follow auricular flutter. The usual rates in the ectopic tachycardias are

between 150 and 250 per minute, while in auricular flutter the ventricular rate will vary with the degree of A-V block. The commonest ectopic rhythm in this group is paroxysmal auricular tachycardia, which occurs frequently in the absence of organic heart disease and may be associated with excessive use of tobacco, coffee or alcohol, systemic infections, severe fatigue, thyrotoxicosis, or digitalis poisoning. Auricular flutter and ventricular tachycardia are more often associated with organic heart disease, but may occasionally be functional. Symptoms such as palpitation, dyspnea, angina, nausea or vomiting, apprehension and syncope may accompany these rapid rates which, if prolonged, may lead to congestive failure. In auricular tachycardia, the heart is generally absolutely regular, while in ventricular tachycardia slight irregularity is the rule, but this feature cannot be relied upon for differentiation. In auricular tachycardia (in the absence of A-V block), there will be a jugular pulse for each ventricular beat and the heart sounds will not vary in quality, while in ventricular tachycardia, the auricular jugular pulsations are less than the apical rate, some of the pulsations are unusually vigorous, and there are variations in the heart sounds depending on the temporal relationship of the auricular and ventricular contractions. In auricular flutter, rapid auricular pulsations occasionally may be seen in the jugular veins, most commonly with a 2:1 relationship to the apical beats. In the differentiation of the ectopic tachycardias and auricular flutter from sinus tachycardia, the response to exercise, deep breathing, postural change, or inhalation of amyl nitrite is helpful, since the rate of a sinus tachycardia is influenced by these measures while the others are not (although rarely exercise may decrease the block in auricular flutter and lead to acceleration of the ventricular rate). Carotid sinus pressure may terminate the rapid rate of auricular tachycardia. In auricular flutter, carotid sinus pressure may lead to sudden halving of the ventricular rate by converting a 2:1 A-V block to a 4:1 block; however, other degrees of block (3:1, 6:1, or even 8:1) may occasionally be produced, and confusion may be avoided if an exact mathematical ratio is found to exist between the rates preceding and during carotid sinus pressure. An irregular rhythm may be noted during carotid sinus pressure in auricular flutter if a varying block is produced. The rate in auricular flutter frequently returns to its original level after release of the carotid sinus pressure or after exercise. In sinus tachycardia, carotid sinus pressure may produce slight slowing of the rate, and in ventricular tachycardia it has no effect.

An irregular rhythm may be due to auricular, nodal, or ventricular extrasystoles, sinus arrhythmia, sino-auricular block, auricular fibrillation, auricular flutter with varying degrees of A-V block, incomplete A-V block with irregularly dropped beats, auriculo-ventricular dissociation with interference, or paroxysmal ventricular tachycardia (which has already been discussed). The relation between respiration (normal or deep) and changes in heart rate serves to differentiate sinus arrhythmia from the other causes of irregular rhythm, the rate generally accelerating with inspiration and slowing with expiration in sinus arrhythmia.

With extrasystoles, sino-auricular block, partial A-V block, and A-V dissociation with interference, the basic heart rhythm is regular and is interrupted either by premature beats or long pauses or both. Sino-auricular block and A-V dissociation with interference are uncommon, usually of little clinical significance (except that these arrhythmias may result from digitalis administration occasionally, and sino-auricular block, if prolonged, may lead to syncope), and may be regarded as analogous to marked sinus arrhythmia.

In auricular fibrillation (in the absence of complete A-V block) the ventricular rhythm is wholly irregular, while in auricular flutter with varying block periods of irregularity may alternate with periods during which the block is transiently stabilized at one level or another. In partial A-V block, the underlying regular ventricular rhythm may be broken by pauses during which auricular pulsations may be seen in the jugular veins.

Exercise is often of great assistance in differentiating irregular rhythms. Speeding up the ventricular rate will decrease the irregularity of sinus arrhythmia and decrease or eliminate extrasystoles. In partial A-V block, the ventricular rate may accelerate and become regular after exercise, or the degree of block may increase and the ventricular rate become slower. Auricular flutter with variable block may develop a more stabilized degree of block after exercise and the ventricular rate may become regular. The irregular irregularity of auricular fibrillation persists or becomes more marked after exercise. The quality of the heart sounds, the force of the pulse, and the height

of the systolic blood pressure vary most markedly in auricular fibrillation. Auricular fibrillation and flutter and A-V block are most commonly seen in the presence of organic heart disease, although they may occur in its absence, while extrasystoles and sinus arrhythmia are more often encountered in the absence of heart disease.

Having determined the mechanism of an arrhythmia by clinical study and, preferably, verified it by electrocardiography, the problem of rational management arises. Complete A-V block is potentially one of the most dangerous arrhythmias. It is a serious condition which does not, however, necessarily indicate the presence of organic heart disease. Transient A-V block may be due to poisoning with digitalis or quinidine, infections (e.g., diphtheria, rheumatic fever) or myocardial anoxemia. Permanent A-V block is most commonly due to coronary arteriosclerosis with resultant myocardial degeneration and fibrosis, or myocardial infarction. Other rarer causes include gummata of the septum, congenital interventricular septal defects, trauma, neoplasms involving the heart, et cetera. The danger in A-V block lies in the possible development of ventricular standstill with resultant cerebral anoxemia leading to syncope and convulsions (Adams-Stokes syndrome) or to death. The treatment of the A-V block should be directed to its cause insofar as is possible (e.g., discontinuation of digitalis or quinidine in those cases where it is responsible for the block). Further management depends on the prevention of attacks of Adams-Stokes syndrome.

Many drugs have been studied in attempts to prevent the syncopal attacks in advanced degrees of A-V block. Adrenalin is probably in widest use for this purpose, and reports[9] indicate that it may have the following effects in A-V block:

1. It may increase the ventricular rate without affecting the block.
2. It may decrease the degree of block.
3. It may prevent syncopal attacks without accelerating the idioventricular pacemaker or modifying the degree of block.

Subcutaneous or intramuscular injection of 0.5 c.c. of the 1:1,000 solution of adrenalin hydrochloride at intervals of two to four hours during periods when episodes of ventricular standstill are frequent has been found effective. The intramuscular use of 1 c.c. of adrenalin in oil once or twice daily, with massage of the injection site when indicated, will reduce the number of injections necessary. In the event of ventricular standstill for longer than a few seconds with the possibility of imminent death, the intracardiac injection of 1 c.c. of 1:1,000 adrenalin may be tried.

Ephedrine hydrochloride, in doses of 15 to 30 mg. three to six times daily, has proved efficacious in some instances of complete heart block in preventing syncopal seizures by accelerating the idioventricular rate.

Paredrine (parahydroxyphenylisopropylamine), a drug related in chemical structure to adrenalin and ephedrine, exerts an adrenalin-like action in A-V block which is however less intense and more prolonged than that of adrenalin. In doses of 60 mg. three times daily, it has proven effective in preventing syncopal attacks in A-V block.[9]

Barium has a digitalis-like action on the myocardium, increasing its contractibility and excitability. The rate is accelerated especially if it has been low.[7] Because of this effect on heart rate, barium chloride in doses of 30 mg. three to four times daily has been used in the prevention of Adams-Stokes attacks with effective results in occasional cases. Thyroid extract and atropine have also been tried, but successful results with these drugs are infrequent.

Occasionally, such simple measures as pounding the precordium with the fist may restore ventricular activity.

Before leaving this topic, it is essential to emphasize that the drugs discussed above are indicated only in attacks of Adams-Stokes syndrome resulting from ventricular standstill in auriculoventricular block. Paroxysmal ventricular fibrillation and prefibrillatory ventricular tachycardia are other cardiac mechanisms which may produce the clinical features of Adams-Stokes syndrome, and in such mechanisms adrenalin may be fatal by precipitating or perpetuating ventricular fibrillation. Quinidine has been used in the prevention of paroxysms of the prefibrillatory type of ventricular tachycardia, but quinidine also may cause ventricular fibrillation.

In paroxysmal auricular tachycardia, the attack may subside spontaneously if the patient is permitted to rest, given mild sedation, and reassured. If symptoms are distressing, or the attack has lasted more than an hour or two, more active measures are indicated and these ususally have as their objective stimulation of the vagus nerves which leads to slowing of the auricular rate and de-

creased irritability of the auricular muscle. Such simple measures as abrupt changes in posture, vigorous, deep respiration, holding the breath in full inspiration or expiration, Valsalva's experiment, stimulation of the gag reflex by a tongue blade, forceful pressure on the eyeballs, or pressure with massage of either carotid sinus may be efficacious. The dramatic cessation of the attack if one of these measures is successful is extremely gratifying to both the patient and physician, and these simple procedures should all be tried before recourse to drugs since they are effective in the majority of instances. Patients who have frequent attacks of paroxysmal auricular tachycardia often learn by experience which maneuver will abort their attacks, and apply it themselves. If these efforts prove unsuccessful, the induction of vomiting by the administration of syrup of ipecac in doses of 8 c.c. every half hour for a maximum of four doses may be tried, provided the patient's clinical condition permits temporizing. Apomorphine hypodermically acts more rapidly in producing emesis, but its side-effects may be dangerous and its use is not advised. Magnesium sulfate intravenously in a dose of 15 to 20 c.c. of the 20 per cent solution given in about thirty seconds has been successful in terminating attacks of paroxysmal tachycardia,[2] although it is advised that caution be used in the presence of advanced myocardial damage. Quinidine sulfate in dosage of 0.2 gm. every hour for six to eight hours is one of the best measures available.

For critically ill patients, the slow intravenous administration of quinine dihydrochloride or quinidine sulfate in doses of 0.4 gm. at four-hour intervals may be useful. Mecholyl (acetylbetamethylcholine chloride) is often rapidly efficacious in stopping paroxysmal auricular tachycardia, but its side-effects may be very distressing. It should be avoided in patients with hyperthyroidism or asthma. The patient should be recumbent and should be warned of the possible reactions such as intense sensation of warmth, salivation, lacrimation, sweating, involuntary defecation, and hypotension. In the event the reaction is marked, a tourniquet should be placed above the site of injection to delay absorption. A syringe containing 1 mg. of atropine should be at hand for intravenous use to counteract marked side-effects or collapse. Mecholyl should be given subcutaneously, starting with a small dose such as 10 mg. If there is no effect within twenty minutes, massage of the site of injection followed by carotid sinus pressure should be tried. If there is still no effect, a dose of 20 mg. may then be given. It is unwise to start with the injection of 25 mg. of mecholyl, the usually recommended dose, since reactions are too frequent after such amounts.

If these foregoing measures fail or if cardiac failure is present or imminent, relatively rapid digitalization should be instituted. It should be remembered that digitalis toxicity may produce paroxysmal tachycardia; however, in proper dosage digitalis is useful in terminating attacks.

If the attacks of paroxysmal auricular tachycardia are of recurrent nature, primary attention should be given to their prevention. Possible causative factors such as tobacco, coffee, alcohol, severe fatigue, thyrotoxicosis, or excessive digitalis administration should be eliminated. Mild sedation with bromides or barbiturates may be all that is necessary to avert attacks, particularly in those patients in whom attacks are precipitated by emotional storms. Quinidine sulfate, 0.2 gm. three times daily, is the drug of choice in preventing recurrent attacks. Should it, however, prove unsuccessful, digitalization should be tried (keeping in mind, of course, that overdosage may produce similar attacks).

Potassium salts have been advocated for the prevention and treatment of paroxysmal tachycardia, but it is unlikely that their oral administration provides sufficient concentration of potassium ion for effect on the myocardium.[7]

Paroxysmal ventricular tachycardia is most commonly caused by digitalis overdosage, but may be due to advanced arteriosclerotic heart disease with or without myocardial infarction, and may occur in patients with apparently normal hearts. The ventricular tachycardia which is due to digitalis poisoning is often bidirectional in type electrocardiographically, and may subside in twenty-four hours if the administration of digitalis is stopped. The danger of ventricular tachycardia lies in its closeness to ventricular fibrillation. Ventricular tachycardia due to myocardial infarction may persist for several days, and it may be associated with infarction which is clinically relatively mild.

In the management of paroxysmal ventricular tachycardia, the intravenous injection of 20 c.c. of 20 per cent magnesium sulfate should probably be tried first. If this is unsuccessful, oral quinidine in relatively large amounts such as 1 gm. per hour for six to eight doses may be used,

if idiosyncrasy has been ruled out by a small test dose. Occasionally, the addition of 2 mg. of atropine sulfate subcutaneously after a large dose of quinidine may be successful in restoring normal rhythm.[8] As a last resort, intravenous or intramuscular quinidine may be tried. It must be remembered that quinidine is not an innocuous drug, and it may cause ventricular fibrillation or standstill; therefore, its use should be accompanied by full appreciation of its possible hazards. In the prevention of attacks of paroxysmal ventricular tachycardia, quinidine in smaller dosage (0.3 gm. two or three times daily) is the best available measure.

The treatment of an attack of paroxysmal auricular flutter which does not subside spontaneously or is associated with congestive failure should begin with digitalization of the patient. Digitalis may act in two ways in flutter:

1. By depressing conductivity in the junctional tissues and increasing the degree of A-V block, the ventricular rate is slowed.

2. By its stimulant effect on the vagus, the refractory period of auricular muscle is decreased and the rate of conduction of the excited state is increased leading to auricular fibrillation.

In about half of the patients with auricular flutter, the second mechanism, i.e., the establishment of auricular fibrillation, follows the first, and if digitalis is stopped when fibrillation develops, regular sinus rhythm may return within a few days.

Quinidine is also a valuable drug in the treatment of auricular flutter. In the absence of congestive failure, and with a flutter of relatively brief duration (i.e., not more than a few days), quinidine may be used as the initial treatment. Quinidine depresses conductivity in the junctional tissues, increases the refractory period of myocardial tissue and slows the rate of transmission of the excited state by its depressant action on the vagus and by direct action on the myocardium. However, in some patients with flutter, the ventricular rate accelerates after the administration of quinidine; therefore, apart from the possibly overemphasized risk of producing embolism, it is perhaps wiser to reserve quinidine for those cases of flutter which fail to respond to the administration of digitalis as described above.

In the prevention of recurrent episodes of paroxysmal auricular flutter, primary attention should be given to the elimination of possible causative factors such as thyrotoxicosis, infections, excessive fatigue, excessive tobacco, coffee, alcohol, and so on. Maintenance dosage of digitalis or quinidine may be necessary.

Paroxysmal auricular fibrillation is a common arrhythmia which may be organic or functional in origin, and may subside spontaneously within a few minutes. If the arrhythmia persists beyond a few days, it may become fixed unless treated. Quinidine is effective in restoring sinus rhythm, but should probably not be used for patients in congestive failure, for patients who have been fibrillating for a few weeks, for patients who have had embolic episodes, and patients with severe organic heart damage. In these exceptions, digitalization is the procedure of choice. In patients with auricular fibrillation secondary to thyrotoxicosis, digitalis is less effective than thiouracil or iodine in slowing the ventricular rate, and established auricular fibrillation often ceases spontaneously after thyroidectomy. Rarely, patients may develop auricular fibrillation for the first time following thyroidectomy, but it is generally of brief duration and subsides spontaneously.

The administration of quinidine in those cases where it is advisable should be preceded if possible by a few days of rest and sedation. Patients with rapid ventricular rates should preferably be digitalized before the exhibition of quinidine to prevent the occasional acceleration of the ventricular rate which may follow quinidine. The administration of quinidine to any patient should be preceded by a test dose of 0.2 gm. to rule out idiosyncrasy, the symptoms of which are nausea, vomiting, vertigo, cyanosis, or respiratory difficulties. The optimal dosage of quinidine is 2 gm. daily, given in five doses of 0.4 gm. each at four-hour intervals. The patient should be observed carefully for possible symptoms of cinchonism (disturbances of hearing and vision, tinnitus, vomiting, diarrhea, dermatitis, headache, fever, or respiratory distress). In the event that symptoms of toxicity or severe tachycardia develop, the drug should be discontinued immediately. Sudden death during quinidine administration may be due to embolism, cardiac standstill or ventricular fibrillation.

If, following the administration of quinidine for three days, the fibrillation continues, digitalis should be substituted. Another course of quinidine may be tried after an interval of at least a week.

In the prevention of recurrent attacks of paroxysmal auricular fibrillation, the usual precipitating or contributory causes should be eliminated. If these measures are not entirely successful, the administration of quinidine in dosage of 0.2 gm. one or more times daily plus mild sedation is usually effective. Digitalization and maintenance on digitalis may be advisable should quinidine fail to prevent frequent disturbing paroxysms of auricular fibrillation. The digitalis prevents undue acceleration of the ventricular rate during the attacks and may convert the rhythm to a well-controlled permanent auricular fibrillation which might be less disturbing to the patient.

Myocardial Infarction

There have been several review papers in the recent literature dealing with the cause, diagnosis, and prognosis of myocardial infarction.[1,11] The occurrence of infarction without coronary occlusion, and the relatively frequent incidence of infarction with few or no clinical manifestations ("silent coronaries") are more widely appreciated. We shall therefore limit ourselves to a brief discussion of the management of the acute episode.

The objectives of the immediate therapy are fourfold:

1. To relieve the pain and accompanying shock.
2. To reassure the patient.
3. To prevent extension of the infarcted area by minimizing reflex constriction of neighboring coronary vessels.
4. To prevent complications such as embolism, congestive failure, arrhythmias, and ventricular aneurysms.

Rest remains the most important measure in the management of myocardial infarction for obvious reasons; however, the routine use of "absolute bed rest" must be tempered with common sense. We have all seen patients who are strained severely, mentally and physically, by having to use a bedpan, and in such patients it would seem the better part of wisdom to permit bathroom privileges as early as possible. The sedimentation rate remains the best *laboratory* guide for the duration of rest, but the clinical condition of the patient is naturally of primary importance.

Morphine is the most popular drug used in the acute phase of infarction, yet it has no circulatory effects of significance. Its value depends on its analgesic qualities, and its ability to decrease the apprehension of the patient, thus aiding homeostatic mechansims in counteracting shock. Morphine is generally necessary only in the first few hours following the myocardial insult, and frequently only one dose is necessary for the relief of the severe pain. If the pain is excruciating, the slow intravenous administration of morphine in dosage of 8 to 10 mg. may produce very prompt alleviation. Following subcutaneous or intramuscular injection, there is a delay of twenty to thirty minutes before its effects are manifest. When the pain has dulled, it is wise to discontinue the use of morphine, or to replace it with another analgesic and/or sedative for two reasons:

1. The respiratory depression which may develop in sensitive patients, or with overdosage, constitutes an added hazard in the presence of an anoxemic myocardium.
2. Many patients develop nausea and vomiting following morphine administration, and the violent muscular efforts incidental to vomiting are hardly restful. In such patients it may be possible to obviate the vomiting by dividing the indicated dose of morphine in two and giving the second half twenty minutes after the first.

The administration of oxygen during the acute period may aid greatly in the relief of pain and in the provision of oxygen to the relatively ischemic myocardium bordering on the zone of ultimate infarction. However, it must be realized that the arterial blood usually has a normal oxygen content in coronary occlusion, and our purpose in supplying additional oxygen is to "hyperoxygenate" the arterial blood, primarily by adding to the oxygen in solution in the blood, since the increase in hemoglobin saturation could be only very slight. For this purpose, high concentrations (100 per cent) of oxygen are necessary, and these concentrations cannot be obtained at present with oxygen tents or nasal catheters; therefore, the use of a mask of the B-L-B type is advised. Such high concentration of oxygen should not be given continuously for more than one day, since it may irritate the lungs.

In the limitation of reflex coronary constriction in the region of the infarct, we have available three useful drugs: (1) papaverine in dosage of 30 to 65 mg. intravenously, (2) atropine subcutaneously in 1 mg. doses, and (3) aminophylline intravenously in dosage of 0.25 to 0.50 gm. The administration of any of these at intervals of four to six hours during the acute stage of infarction may help in minimizing the extent of the ulti-

mate necrosis, since observation in experimental animals indicates that these drugs enhance coronary blood flow.[4] In using aminophylline intravenously it is important that it be given slowly, taking about five minutes for the injection, because if injected rapidly it may precipitate arrhythmias.

Some of the cardiovascular complications of myocardial infarction which may be encountered should be specifically mentioned.

Profound Shock.—In the period immediately after occlusion, severe shock may be manifest and the patient may appear moribund. Adrenalin, 0.5 c.c. subcutaneously, may be life-saving under such circumstances. Coramine or caffeine-sodium-benzoate intramuscularly or intravenously may also be helpful. Slow plasma infusions have been used in some cases, with success in a few and with regret in others. Neither adrenalin nor plasma should be used for profound shock accompanying myocardial infarction without full consideration of their potential dangers in the presence of an irritated heart and an over-burdened circulation.

Arrhythmias.—In addition to our previous comment, it is necessary to mention that frequent ventricular extrasystoles following infarction are indicative of heightened myocardial irritability and may precede ventricular tachycardia or fibrillation. The cautious use of quinidine may be valuable because of its action in decreasing the irritability of the myocardium. Papaverine may be safer than quinidine for this purpose since it is a coronary vasodilator, does not act as a myocardial depressant, and is not as toxic as quinidine.[3] When administered orally in 0.1 to 0.2 gm. doses three to five times daily, or intravenously in 0.06 to 0.10 gm. doses, it reduces the frequency of extrasystoles.

Congestive Heart Failure.—Although acute pulmonary edema may complicate myocardial infarction, the classical picture of congestive failure is rarely seen until several weeks later. The treatment of such congestive failure follows the usual pattern of digitalization and allied measures, but in my opinion digitalis should be preceded and accompanied by quinidine in most instances of congestive failure following recent infarction.

Pulmonary Infarction.—Because of the enforced bed rest, the dehydration which may develop after profuse perspiration, vomiting, and limited fluid intake, and the diminished *vis a tergo* of the blood flow, conditions are favorable for peripheral venous stasis and phlebothrombosis with the possibility of pulmonary infarction. The clinical signs of pulmonary infarction are often misattributed to extension of the original area of myocardial infarction or to a new coronary occlusion. Electrocardiographic signs of pulmonary infarction may be masked by the pattern of the myocardial infarct. However, the combination of noncentral chest pain, hemoptysis, increased dyspnea and cyanosis, tenderness to percussion over the infarcted area of lung, accentuation of the pulmonic second sound, pleural friction rub, and signs of pulmonary consolidation within a few hours should permit bedside recognition of the larger infarcts.

The prophylaxis of peripheral venous thrombosis consists in passive motion and massage of the legs during the period of absolute rest, frequent change of the patient's position in bed, adequate fluid intake, and the use of anticoagulants. Frequently, however, the pulmonary infarct is the first indication of the presence of venous thrombosis.

The treatment of pulmonary infarction may be divided into two aspects:

1. Treatment of the infarct itself with opiates, oxygen, measures to combat the accompanying shock, and papaverine intravenously to counteract reflex vasoconstriction.
2. Treatment of the source of the embolus to prevent further thrombosis and embolism, with one or more of the following measures: anticoagulant drugs, lumbar sympathetic block with procaine, or interruption of the common femoral veins.

Peripheral Embolism.—Embolism from a mural thrombus is a hazard in the course of myocardial infarction, and the routine administration of dicoumarol and heparin in cases of myocardial infarction has been studied at several centers.[10] The rationale of using anticoagulants in myocardial infarction is to prevent thrombophlebitis or phlebothrombosis, to prevent extension of the thrombus in the coronary vessel and the formation of new thrombi, and to prevent the formation of mural thrombi. However, since the use of anticoagulants is not without hazard, and since the necessity for frequent laboratory checks of the prothrombin time constitutes a considerable expense to the patient, it seems wiser for the present to reserve the use of anticoagulants for patients in whom specific indications exist, at least until more extensive clinical evaluation is on record.

Rupture of the Heart.—Rupture of the heart wall is not frequent, but occurs most often in the first two weeks following infarction,[6] and the best prophylactic measure seems to be insistence on rest during that period.

Acute Pulmonary Edema

The paroxysmal dyspnea of cardiac patients which is not associated with exertion is known as cardiac asthma. Most commonly, such episodes occur when the patient is asleep, and they may vary greatly in duration and severity. A mild attack may be associated with slight dyspnea, cough, and anxiety, and may subside in a few moments. Severe attacks are terrifying to the patient and his family. Dyspnea, orthopnea and fear are intense. The sense of suffocation frequently impels the patient to run to the window and open it widely. With increase in the degree of pulmonary edema, cyanosis develops and coughing may be productive of copious pink-tinged frothy sputum. The blood pressure during an attack may be depressed or elevated depending on the balance between diminished left ventricular output and vasoconstric-

tion due to asphyxia.[5] Physical signs over the lungs vary with the severity of the attack and the degree of accompanying bronchial spasm. With mild episodes, tachypnea may be the only finding of note. Sibilant expiratory râles with prolongation of the expiratory phase of respiration may be found in the presence of bronchial spasm. With increase in the amount of edema, medium and large moist râles become audible.

Paroxysmal dyspnea is associated with cardiac disorders which strain the left ventricle predominantly, such as hypertension and aortic valve disease, and is associated with pulmonary congestion. Evidence of hypertension in the lesser circulation may be found in the accentuated second pulmonic sound which is often heard during the attack.

With the development of peripheral edema and hepatic congestion (right ventricular failure), the attacks of paroxysmal dyspnea frequently subside, presumably as a result of the redistribution of the fluid load.

In the prevention of paroxysmal nocturnal dyspnea, sedation and an orthopneic sleeping posture may be helpful; however, these measures do not directly affect the failing left ventricle; digitalization, the use of diuretics, and restriction of salt intake are the bases of proper prevention.

The treatment of the acute attack of pulmonary edema is directed toward decreasing cerebral sensitivity, decreasing the venous return to the heart, the alleviation of anoxemia, and the stimulation of the failing left ventricle. The parenteral administration of morphine will relieve the milder attacks usually without additional measures, and the relative euphoria induced in the frightened patient will be gratefully appreciated. Atropine should be combined with the morphine to aid in reducing secretions and to lessen the emetic propensities of the morphine. In more severe attacks, oxygen will be necessary. Breathing of oxygen under positive pressure has been tried in the management of pulmonary edema due to heart failure but proof is lacking that the edema fluid is forced back (although the pressure breathing may help overcome bronchial spasm). Diuresis promoted by the use of mercurial diuretics or hypertonic glucose is helpful. Aminophylline, intravenously in dosage of 0.5 gm. given slowly, is often of great help since it relaxes the bronchial musculature, stimulates the heart, and promotes diuresis.

Venesection with removal of 300 to 500 c.c. of blood may be life-saving in pulmonary edema, but should be preceded by the foregoing measures if possible. So-called *bloodless phlebotomy* may be helpful and is performed by placing tourniquets or sphygmomanometer cuffs on the four extremities to occlude the venous return; the tourniquets should be left on for ten to fifteen minute periods, followed by three to four minutes of release.

In patients with severe acute pulmonary edema who do not respond to the measures described, rapid digitalization with one of the glycosides is indicated.

Summary

We have reviewed briefly some of the emergencies which may punctuate the course of heart disease, namely, acute cardiac compression, cardiac arrhythmias, myocardial infarction, and acute pulmonary edema.

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ORIENTATION COURSE IN ALLERGY

Almost every practitioner of medicine encounters allergic problems in his practice. Most of the practicing physicians have had little if any opportunity to obtain the basic knowledge concerning allergy while they were medical students. To remedy in part this deficiency and to provide the demand for an up-to-date coverage of the field of allergy, Northwestern University Medical School and the American Academy of Allergy offers an Orientation Course in Allergy, October 25 to 29, inclusive.

Allergic Parotid Swelling

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SINCE 1879 several reports have been noted in which parotid swelling has been either suggestive of or proven to be of allergic origin. Burton-Fanning[1] in 1925 reported a case of a sixty-two-year-old man whose attacks began with aching and stiffness of the angles of the jaw, followed in a few minutes by dryness of the mouth and sneezing. Then both parotid glands began to swell simultaneously and symmetrically. Injection of epinephrine terminated the attacks more quickly than when not given. Meyer[3] in 1934 reported a case of recurrent parotid swelling in a child associated with the passage of ropy saliva; the condition was unilateral but involved either side at different times. It is of interest that the mother and the grandmother of the patient suffered from similar symptoms. Sialograms showed dilatation of the minor ducts. Positive skin tests were obtained to spinach and bacon; the elimination of these foods and chocolate resulted in symptomatic relief. Pearson[4], in 1935, reported seventeen cases, in which inflammation played a minor role in eleven, and called attention to the frequent association with allergic disease in either the family or personal histories of these individuals. In three of his patients other allergic symptoms occurred simultaneously with the parotid swelling, and in one case saliva containing mucous plugs packed with eosinophils could be expressed from both Stenson's ducts.

Hansel, in discussing a report by McCaskey[2] in 1942, stated that allergy may have played an etiological part in this case, and Hansel further stated that during a period of one year he had seen five cases of allergic parotitis. Waldbott and Shea[14] recently reported three cases of recurrent parotid swelling in asthmatics who were relieved by allergic management. The authors point out that the actual swelling may be caused by obstruction of the ducts due to allergic edema or by plugs of mucus similar to those seen in the bronchi in bronchial asthma. Although an alternate theory of allergic edema in the gland tissue itself is mentioned, they favor the former mechanism as the most likely cause.

Several case reports, including those by Pearson,[4,5] have pointed out that swellings occurring in patients after eating were often relieved by massaging the parotid gland, which resulted in the expression of ropy mucus. Certain of these cases were not relieved by massage early in the attack but only as it was subsiding, suggesting that edema of the ducts, as well as mucous plugs, may play a part in the etiology. On many occasions sialograms have demonstrated dilatations in the duct systems suggestive of intermittent obstruction. However, our case, reported herewith, was not relieved by massaging the gland nor was the swelling ever relieved by the passage of mucous plugs. The saliva from the duct was invariably observed to be thin and serous in nature and contained few or no cellular elements. So it is probable that mucous plugs, allergic edema of the ducts and edema of the gland tissue itself may all play a part in causing the swelling. It is likely that these factors along with secondary infection may in time result in dilatation of the duct system and an actual destruction of the gland substance itself.

Allergy has not usually been considered in the differential diagnosis of salivary gland swellings. It is with this thought in mind that we are reporting our observations in this case, hoping again to call attention to this fact.

Case Report

Mrs. A. H., fifty-four-year-old wife of a turkey farmer, was referred by one of us (F) for allergy study, with the suspected diagnosis of allergic parotitis. She had been a known diabetic under treatment with a weighed diabetic diet and protamine zinc insulin. On October 10, 1946, she developed a constant painful swelling of the left parotid gland. When she arose each morning, there was edema of the entire left side of the face, including the eyelids; simultaneously, there was always increased parotid pain and swelling. Later each morning the facial swelling would subside entirely, but the left conjunctiva would become injected, coincident with the complaint of a sensation as if there were sand in her eye. Usually these morning exacerbations of the symptoms mentioned were associated with headaches, nasal stuffiness, sneezing, severe exhaustion, a sense of mental dullness and confusion, and not infrequently vertigo, nausea and vomiting. Shortly after the onset of the above complaints there were frequent attacks of burning, redness, itching and swelling of the lower extremities, associated with an aching of the muscles of the legs and thighs. Along with this symptomatology in the feet and legs, there would sometimes be an as-

sociated tightness and puffiness of the skin of the hands; these symptoms always appeared in the morning on rising and tended to subside after an hour or two.

For the past five years she had been in close contact with turkeys and chickens and had eaten fowl twice a day, three or four times a week. Under close questioning she was able to relate three instances where exposure to fowl was followed by symptoms which seemed to bear a cause-and-effect relationship. The first instance followed spending a cold night in the brooder house to insure keeping the young turkeys warm; the second occurred after she had caught a turkey and carried it back into the coop; the third after eating heartily of roast turkey.

No family history of allergic disease could be obtained. The past history was noncontributory, except that as a child she had had mumps in both parotid glands. Her appendix had been removed, and she had been for the past five years periodically treated for a urinary tract infection which had recently been pronounced cured.

During the five-year period prior to the onset of the present illness the patient stated that she suffered from nasal stuffiness and sneezing when exposed to house dust. Upon close questioning she stated positively that whenever she was near the turkeys, and particularly when she was in the turkey coop, she was subject to these same nasal symptoms. She remembered that at times when she came out of the turkey coop she experienced a sensation of vertigo. She slept on feather pillows, used a down comforter, and she noted that shortly after retiring there was an increase in the severity of the nasal reaction. One clear-cut and almost constant symptom-pattern occurred immediately after getting out of bed in the morning and was characterized by increased nasal obstruction and stuffiness, bouts of sneezing, "running of the nose" and excessive quantities of mucus in the throat. From time to time during the past several years she had been conscious of itching of the alae nasi, and she had scratched her nose frequently.

For the past eight years, headaches had been a major complaint, and they varied in frequency from once or twice a week to almost constantly since the onset of the parotid swelling. They were described as throbbing in character and were localized in the back of the neck and the base of the skull. Associated with the onset of the headaches was a sense of "utter exhaustion," mental dullness and forgetfulness. Frequently after such attacks she was restless during the night and slept fitfully. After the onset of the parotid symptoms she appeared to be continually fatigued, a complaint which was most troublesome to her upon rising in the morning and seemed to be slightly relieved as the day progressed.

Inquiry into the gastrointestinal history revealed recurrent attacks of right upper quadrant pain, associated with nausea and vomiting, which necessitated hypodermic injections of morphine for relief. There were periods during which she complained of upper abdominal pains which, from the description, were interpreted as being colonic in origin. On several occasions during the past five years she had attacks of almost constant nausea, lasting several weeks at a time, and during one of these periods she had associated upper abdominal cramps and frequent vomiting. At this time she was under the care of a urologist, and an intravenous pyelogram revealed a low grade hydronephrosis of the left kidney. A cholecystogram at this time showed a normal and well functioning gall bladder.

Since 1941 she periodically complained of "lightheadedness," dizziness and pains in the hands, associated with numbness and tingling. Because she was a diabetic these symptoms had been interpreted as complications of that disorder.

At the onset of her parotid symptoms, her physician suspected a low grade pyogenic infection and consequently prescribed sulfadiazine. When several weeks of this treatment failed to effect relief, she was given x-ray therapy with no benefit. At this time she was referred to one of us (F). Sialograms taken after the injection of 1.0 c.c. of iodochlorol into the left Stenson's duct revealed good arborization and the complete absence of irregularities or dilatations. There was no evidence of concretion or obstruction in the duct system. Efforts were made to obtain a smear from the left Stenson's duct for eosinophils, but the secretions were serous and contained no cellular elements. The nasal smears, performed in the manner described by Hansel, revealed microscopic fields with as high as 80 per cent eosinophils. On the basis of the history and these findings, allergic parotitis was suspected and an allergic study was undertaken.

Physical examination revealed a moderately obese white female. Her weight was 167½ pounds, height 60 inches, pulse 76 and regular, temperature 98° and respirations 17 per minute. The blood pressure was 130/70. There were no skin lesions, but there was a tender swelling of the left parotid gland anterior to and below the left ear. There was no redness or other signs of an acute inflammatory process in the tissues over the gland. There was no edema of the face or eyelid, nor was there any evidence of edema of the extremities. The vessels of the fundi were moderately sclerotic. The right ear showed marked mixed deafness, and examination of the right ear drum revealed a marginal perforation of a quiescent cholesteatoma. The left maxillary sinus transilluminated less well than the right. There was a moderate deviation of the nasal septum to the right, and the nasal membranes were pale and slightly edematous, suggestive of an allergic etiology. The tonsils were moderate in size, scarred, and presented evidence of mild infection. Examination of the mouth showed well-fitting upper and lower dentures and no ulcerations or lesions of the mucous membranes. The orifices of both Stenson's ducts were normal. They were neither patulous, elevated nor congested. Examination of the neck, chest wall, breasts, lungs, heart, peripheral arteries, skeletal and nervous systems revealed no abnormalities. The right kidney was palpable but not tender. Aside from the abdominal surgical scars, the examination of the abdomen was negative.

White blood cell counts taken by her physician since the onset of the parotitis varied from 11,200 to 14,000 per cu. mm. On the date of her examination her red blood cell count was 4,510,000; hemoglobin, 90 per cent; white blood cell count, 12,000, with 53 per cent lymphocytes, 42 per cent neutrophils, 4 per cent eosinophils and 1 per cent monocytes. Urinalysis revealed a 1-plus sugar

but was negative for albumen; the sediment showed only an occasional epithelial cell.

A diet history revealed that the foods most frequently ingested were wheat, corn including corn oil, corn starch and corn sugar, eggs and fowl. Milk was avoided as such "because it disagreed with her," but she used this food in cooking in the form of milk, cream, butter or cheese.

Scratch tests were done only to the inhalants, and clinically significant reactions were found to feathers, cattle hair, orris root, Endo house dust and alternaria. She was titrated to house dust, using the method described by Rinkel,[10] and it was found that she reacted to a dilution of 1:25,000 with a 7 mm. wheal and a 20 mm. erythema. She was given .15 c.c. of this dilution of house dust hypodermically. Instructions were given that she properly cover her feather pillows, remove the down comforter, avoid contact with chickens and turkeys, use hypoallergic cosmetics and eliminate completely the use of fowl in her diet. She was placed on crystalline zinc insulin instead of the protamine zinc insulin to rule out a possible protamine sensitivity. Returning in one week, she stated that although her nasal symptoms were relieved in part, the symptoms which came on during the middle of the night and immediately on rising persisted. The parotid swelling and other associated symptoms remained essentially unchanged.

Since her symptom pattern conformed to that described by Rinkel[8] as the result of masked food sensitivity due to foods eaten at frequent intervals, the most likely suspects seemed to be turkey, wheat, eggs, corn and possibly milk, all foods which were taken frequently in her diabetic diet. Consequently, individual food tests with wheat, corn, milk and eggs were performed, according to the technique described by Rinkel[9] and confirmed by Randolph and Rawlin.[7] Briefly, these tests are carried out in the following manner: The food to be tested is completely eliminated from the diet for four days, and on the fifth day the patient is requested to come into the office, not having eaten or smoked for the preceding five hours. After the patient has rested for a half hour, white blood cell counts are made, whereupon test feedings are given and similar white blood cell counts taken at twenty-minute intervals for one hour thereafter. Another test feeding is then given, and the patient is observed closely for the occurrence of symptoms.

On the third day after fowl, wheat, corn, milk and eggs were avoided prior to testing, the patient stated the parotid swelling almost completely disappeared, as well as the headaches, fatigue and all the other associated symptoms. Then, twenty minutes following the test feeding of wheat, a generalized headache occurred with pains and tightness in back of the neck; this was associated with a decrease in the total white blood cell count of 10.8 per cent from a previous level. The test feeding of milk resulted in belching and nausea, beginning twenty minutes after ingestion, and was followed shortly by vomiting. One hour later she developed a severe headache similar to those described above; she also complained of a stuffy nose and dryness of the mouth. Four hours after the single feeding of milk, she developed edema of the left eyelids, burning and itching of the conjunctiva, extreme dryness of the mouth and then pain and swelling in the left parotid gland. There was an associated diminution of the total white blood cell count of 13 per cent.

Graphs of the corn and egg tests are shown (Fig. 1) to illustrate the fact that while there were no clinical

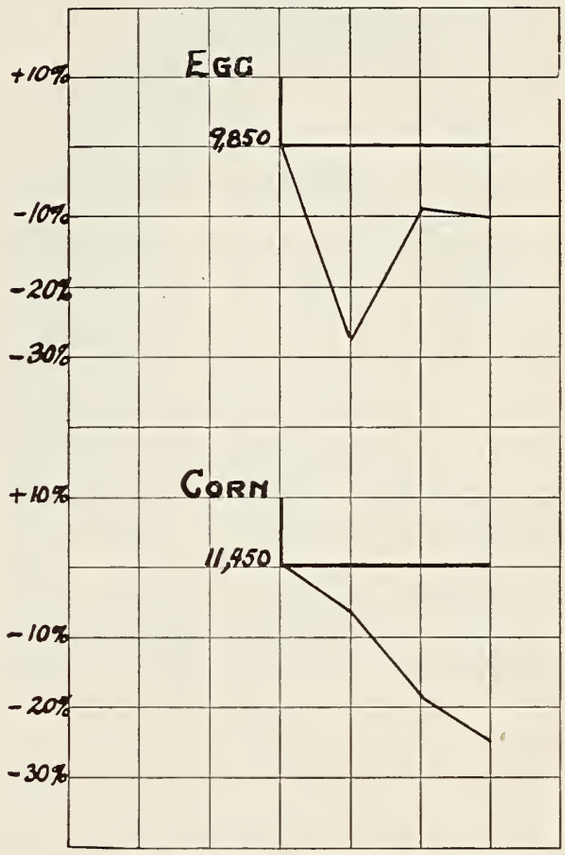


Fig. 1. Leukopenic responses without clinical symptoms in two individual food tests. These foods subsequently produced clinical reactions when later reintroduced into the diet as test feedings.

symptoms following test feedings, there were decreases in the total white blood cell counts of 24.4 per cent in the corn test and 27.4 per cent in the egg test. Curves of this type may be of significance even though there are no clinical symptoms. Patients exhibiting this type of curve frequently will react clinically to these foods when massive feedings are given or if the food is fed repeatedly, resulting in a cumulative effect. This patient, it will be noted, developed symptoms after egg and corn were subsequently added as test feedings to the diet. While the reproduction of the patient's symptoms following test feeding seems to be the most positive way of incriminating a food as the cause of an allergic reaction, the type of curve herein presented should place this food under suspicion until proven otherwise by repeated ingestion.

Summarizing these findings, the wheat and milk tests were followed by a definite reproduction of allergic symptoms. The corn and egg tests were not followed by clinical symptoms but the decreases in the total leukocyte counts were of a degree and type strongly suggestive of sensitivity. On the basis of these facts it might

have been supposed that since there was such a great degree of sensitivity, including the four most commonly used foods, others frequently ingested might also be involved in the allergic process. But since the patient was relieved of her symptoms after withdrawal of these



Fig. 2. Patient one hour after a test ingestion of milk, showing edema of the left side of the face.

foods prior to test feedings, and since she was a diabetic, it was deemed advisable to restrict the diet as little as possible. Therefore, she was placed on a diet eliminating chicken, turkey, wheat, milk, corn and egg. The diet approximated a constant glucose value in the various feedings, and crystalline zinc insulin was administered before each meal. She continued to receive her therapeutic dose of dust extract whenever the nasal symptoms warranted, and she continued to avoid the other inhalant exposures as outlined. Whereas she was symptom-free on the morning of the fourth day of this diet plan, she then deliberately ate turkey and in two hours developed the parotid swelling with pain, edema of the left eye, headache, fatigue and nasal stuffiness, all of which persisted for four hours. She repeated this the next day, although not instructed to do so, "to be sure it was due to the turkey," and the same reaction was reproduced. Thereafter, she strictly followed the diet and inhalant instructions and was entirely free of symptoms, but she noted that whenever she came near the turkeys the nasal stuffiness promptly returned. The subsequent addition of egg to her diet was followed by the production of aching pains in the back of the neck, whereupon eggs were again omitted from the diet. Deliberate ingestion of wheat was followed by a similar symptom response. Subsequently she developed "heartburn" after drinking black coffee, and abdominal cramps after the ingestion of onions, so these were also removed from the diet.

One day she helped her husband catch a turkey, and two hours later she experienced a slight pain and swelling over the left parotid gland, associated with nasal stuffiness. On another occasion she was canning turkey, and though she had not eaten any of the meat, she developed parotid swelling with pain soon after the exposure. On still another occasion after chewing a stick of gum she experienced slight swelling and pain. Whether this mild reaction was due to the corn starch used in powdering the gum we were unable to determine.

Other than the above she was entirely symptom-free until April 20, 1947, at which time she began to have itching of the eyes, with puffiness and redness of the lids, and daily headaches localized to the nuchal region and the back of the neck, associated with fatigue and lassitude. The left parotid gland became tender but there was no swelling. Because this was the date that patients sensitive to box-elder pollen were beginning to react clinically, it was felt that this might be exerting an etiological effect, but titration and treatment with suitable extracts were of no avail.

At this time it was noted that when wheat was omitted from the diet, the dietician substituted feedings of rye, which had been eaten two to three times daily. Beef, pork, oatmeal and rice were also taken at least once to three times daily. These foods were then all temporarily avoided for a test period, which was followed by the complete relief of symptoms on the fourth day. Oatmeal, pork and rice were added one at a time without reaction, but when rye was reintroduced into the diet, she reacted with a headache and "sour stomach." This she repeated on four occasions "to be certain," and each time the same reaction occurred. Beef was subsequently added, with a resultant gastrointestinal upset characterized by nausea and epigastric distress. Consequently, wheat, corn, milk, eggs, rye, turkey, chicken, onions, coffee and beef were eliminated from the diet which was prepared with a great variety of foods so that no food was eaten more often than once every other day in an effort to prevent the development of new sensitivities. The glucose values were constant for each meal, and her insulin requirements were 26 units of crystalline zinc insulin before each meal.

On June 6, the patient consented to drink milk in a deliberate attempt to reproduce an attack of parotid swelling. One hour after the test ingestion of the milk, the parotid gland became tender and swollen and the same nuchal headache, associated with nasal stuffiness, fatigue and edema of the left side of the face, occurred (Fig. 2). These symptoms were relieved two hours after the hypodermic injection of epinephrine.

On June 13, she reacted with epigastric distress after the ingestion of oatmeal, so this food was temporarily eliminated. Shortly therafter, she was again tested to egg, resulting in the development of parotid swelling and pain, nasal symptoms and fatigue lasting for two days. After this she remained completely symptom-free until July 30, at which time the left parotid gland again became chronically tender and swollen and associated with headache, fatigue and nasal stuffiness. Checking over her diet diary, it was noted that she was taking tea several times daily, although she had been warned about the frequent

ingestion of any one food item. After the elimination of tea, she was again symptom-free in three days. At this time her insulin dosage was cut to 21 units before each meal. On August 30 she "tasted a small piece of turkey." Three hours later she had left parotid pain and swelling, associated with nasal symptoms and fatigue. These symptoms disappeared on the afternoon of the third day.

On October 4 it was decided to reintroduce corn into the diet. Ingestion was promptly followed by a headache and soreness of the entire left side of the face, associated with vertigo but without definite parotid swelling. Finally, after several months, beef was added every third day without symptoms; oatmeal was taken every third day without reaction, and corn as such was added once a week and tolerated. When last seen in March of 1948, her fasting blood sugar was 124 mg. per cent. She was on a weighed diabetic diet, in which each food was introduced not oftener than once every other day and most foods every third day, carrying out in principle the details of Rinkel's rotary diversified diet.[11] She has maintained her weight and strength, and has been without symptoms as long as she follows the dietary plan and continues the inhalant therapy as outlined, including the dust injections. It is hoped that in the future, after tolerance is increased by complete avoidance, certain of the foods now eliminated may be added to the diet in spaced feedings.

Since our attention had been called to the allergic etiology of parotid swelling by this case, we have observed in our own practices within a period of one year four other patients in which transitory swelling of the salivary glands have occurred. We are led to the conclusion that this condition is much more common than has previously been suspected. Two of these patients were under treatment for other allergic manifestations, and parotid gland enlargement might have been overlooked in taking the history had not specific questions been directed in regard to the presence of such symptoms.

Comment

The case herein reported is of interest in that the parotid swellings have been produced directly upon exposure to turkey feathers, and on one occasion from the emanation of cooking turkey acting as an osmyl. The precipitation of these attacks after test feeding of foods under experimental conditions leaves no doubt as to the cause-and-effect relationship of food as a factor in the genesis of the attacks. There was only one episode where an excessively large meal of turkey in the original history was known to precipitate a severe exacerbation, even though she ate turkey many times a week. Furthermore, there were no appreciable exacerbations immediately following meals; these findings are what might be expected when one is dealing with a masked food sensitivity. As a matter of fact, the symptoms decreased in severity as the day progressed, in spite of meals in which the offending foods were eaten. Aside from the suspicion of milk, the patient had no knowledge of what foods may have been the cause of her symptoms. These observations tend to corroborate Rinkel's description of masked food allergy.

The performance of the individual food tests, as described, proved to be practical and accurate diagnostic measures. The clinical reactions after the ingestion of wheat and milk left little doubt in the patient's mind that she was allergic to them. On the other hand, the "positive curves," characterized by postprandial leukopenia without clinical symptoms, proved of significance in that when these foods were added subsequently to the diet, clinical reactions did occur. We feel that this in itself justifies taking the white blood cell counts in the individual food tests, although, of course, much more significance is placed on clinical reactions plus the leukopenic response. Certainly, the individual food tests are of much more clinical significance than the leukopenic index as described by Vaughan, [12,13] because in his technique the food tested was not eliminated completely for four days prior to testing. Consequently, prompt significant responses after feeding were often not obtained, due to the fact that the sensitivity was still masked. On the other hand, in most instances, when the food is eliminated for four days and then fed on the fifth day, the tested food is ingested in a phase of hyperacute sensitivity and the symptom response is most often sharp and prompt.

The patient's symptomatic relief from house dust sensitivity, as a result of dust therapy based upon titration, was prompt and persisted for as long as a week at a time following each injection. This method outlined by Rinkel makes possible specific inhalant therapy which is "tailored to the patient," and the treatment can be prescribed individually and accurately instead of employing the orthodox method of graduated dosages starting from a low level and increasing to the point of reaction.

It will be noted that after the patient had been symptom-free for six weeks, she insidiously began to "mask her allergy." Therefore, evidence obtained from the diet diary was of little value in demonstrating the cause-and-effect relationship between the ingestion of an offending food and the production of symptoms; however, it did reveal those foods which were frequently eaten and which might thereby result in the phenomenon of masking. It should be pointed out that rye, which was

substituted for wheat and taken several times daily, was the most likely cause of the recurrence of symptoms; this was borne out by subsequent test feedings after it had been eliminated from the diet for four days. Attention should be called to the fact that if this same food is then eaten on successive days in an effort to substantiate the first test ingestion, that masking may again develop, and the specific cause-and-effect relationship of ingestion of the food and reproduction of symptoms may again be lost due to this phenomenon.

The development of rye sensitivity confirms the contention of Randolph[6] that frequent ingestion of a food in a patient having a low inherent tolerance for food, or a broad base of sensitivity, will often lead to a spread of sensitivity thereto. This same phenomenon was observed in the case of tea and, also to a lesser extent, with beef and oatmeal. On the other hand, avoidance of the latter two foods for a period of time increased specific tolerance to the point that they could be reintroduced into the diet and tolerated at less frequent intervals. It should be pointed out that corn, which was a major reactor originally, was reintroduced into the diet once a week and was tolerated, after it had been avoided completely for a period of several months.

It is hoped that the continued use of a rotary type of diet will prevent the development of new sensitivities in this patient.

It has been our experience, as it has been with others, that the patient must be supplied with adequate information regarding the presence of specific food items in commercial products, and that best results are obtained when the patient is furnished with adequate menus and recipes informing him what to eat rather than what not to eat.

Conclusions

1. A case of allergic parotid swelling associated with other allergic manifestations is reported. The symptoms could be reproduced at will by the exposure to turkey feathers, turkey as an osmyl and by the deliberate ingestion of certain specific foods. Complete relief was afforded by the elimination of these foods and adequate specific inhalant therapy.

2. We wish to point out that this condition occurs more often than previously estimated. It is probably frequently misdiagnosed in respect to its specific etiology.

3. Allergic parotid swelling should be included in the differential diagnosis of painful enlargements in the region of the parotid glands.

4. The individual food tests proved to be practical and specific in the diagnosis of food sensitivity in this patient.

5. The recognition of the phenomenon of masked food allergy was essential in the true evaluation of this patient's symptoms, the diagnosis of her specific food sensitivities and the successful management of her therapy.

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MSMS

CONSULTANTS IN EUROPE

Richard A. Steifel, M.D., Battle Creek, consultant in surgery, and A. James French, M.D., Ann Arbor, consultant in pathology, have returned from a five weeks' tour of European army hospitals. This was the second expedition to the European theater carrying out the army program of postgraduate instruction for the doctors serving in the army in Europe. They flew over and back and had an interesting experience, with the air transport furnishing food and supplies to Berlin being sandwiched in between freight transports. They report quite extensive destruction.

ATTENDANCE AT AMA 1948 SESSION

(Continued from Page 838)

Mogill, George, Detroit, Drake
Mosen, Max M., Detroit, Drake
Ponterson, Lunette I., Muskegon
Rabinovitch, Bella M., Stevens
Rawlings, J. Mott, Flint, Palmer House
Satterwaite, R. W., Battle Creek
Schaeffer, Joseph N., Battle Creek
Schuitema, Donald M., Grand Rapids
Showalter, Laurence E., Cadillac, Dolton, Ill.
Sluyter, John Stanley, Grand Rapids, Sherman
Steele, Arthur H., Paw Paw
TenHouten, Charles, Paw Paw
Torgerson, William R., Grand Rapids
Zbudowski, A. S., Hamtramck, Lakeshore Drive
Zuelzer, W. W., Detroit

Hydryllin in Asthma and Hay Fever

Clinical Results

By Samuel J. Levin, M.D., and

Selma S. Moss, M.D.

Detroit, Michigan



THE VALUE of the antihistaminic drugs for the symptomatic treatment of allergic disease is well established. Numerous reports in the literature attest their value but at the same time emphasize their limitations. Chief of these is the frequency, and occasionally the severity, of the side reactions, which have been reported. Table I summarizes the experience of several observers with benadryl (diphenhydramine hydrochloride) and indicates that the side reactions have varied from 31 to 67 per cent. The same observers report improvement varying from 41.6 to 73.5 per cent. Table II summarizes similar experiences with pyribenzamine (tripelennamine hydrochloride) and indicates slightly less but still significantly frequent side reactions. The percentage of improvement with pyribenzamine was approximately the same as with benadryl. Several other antihistaminic drugs have since been introduced. Among these tried by us are neo-antergen (Merck), histadyl (Lilly) and trimeton (Schering). Our unpublished experiences with these antihistaminic agents indicate that they are approximately equal to benadryl and pyribenzamine, but have slightly less tendency to produce side reactions. However, as previously pointed out, some patients' symptoms are relieved better by one antihistaminic drug than another. The greater the possibility of finding a particular one most suited for, and best tolerated by, any given patient, the greater likelihood of obtaining symptomatic relief.

Most observers are agreed that the antihistaminics are chiefly useful for seasonal hay fever and urticaria. They are of much less value in allergic rhinitis and asthma. As pointed out,[9] they are almost completely devoid of benefit when the asthma is complicated by or induced by a respiratory infection. Because of the poorer results obtained in asthma than in the other allergic diseases, it was suggested[15] that an ideal supplement to benadryl would be aminophylline. The actions of aminophylline are well known. These include its activity as a cardiac stimulant and its decided ability to relax smooth muscle, especially bronchial musculature. It is also a potent diuretic and an effective central nervous system stimulant. According to Goodman and Gilman,[6] the main sites of such stimulation are the cortex, the medulla and the spinal cord. The cortex is more easily stimulated by aminophylline than the medulla. The cord is stimulated only by large amounts of the drug. It has also been demonstrated by Lehman and Young[7] and by Loew, Kaiser and Moore[11] that aminophylline exerts an appreciable antihistaminic effect. The former found that the drug protected 37 per cent of guinea pigs from anaphylactic shock following sensitization by egg white, and Loew and his associates reported that aminophylline effected a 30 per cent reduction of mortality in guinea pigs subjected to atomized histamine.

Benadryl, in addition to possessing antihistaminic qualities, exerts a considerable antispasmodic effect and also has a weak atropine-like action. Both benadryl and pyribenzamine, but particularly benadryl, exert a depressing effect on the central

TABLE I. EFFECT OF BENADRYL (DIPHENHYDRAMINE HYDROCHLORIDE) IN ALLERGIC CONDITIONS

Author	No. of Patients	Per Cent Improved	Per Cent Side Reactions
O'Leary and Farber[12]	186	41.6	31.0
Thacker[14]	72	55.6	67.0
Levin[9]	223	60.5	64.6
Waldbott[15]	165	60.6	55.8
Schwartz and Levin[13]	50	62.0	60.0
Farmer and Spickschen[3]	113	73.5	33.0

TABLE II. EFFECT OF PYRIBENZAMINE (TRIPELENNAMINE HYDROCHLORIDE) IN ALLERGIC CONDITIONS

Author	No. of Patients	Per Cent Improved	Per Cent Side Reactions
Levin[10]	65	41.0	40.0
Friedlaender, Friedlaender[5]	242	52.5	27.2
Chobot[2]	978	54.9	17.2
Leibowitz, Kurstz, and Schwartz[8]	68	58.5	36.0
Arbesman, Koepf, Lenzner[1]	495	67.0	29.4
Feinberg, Friedlaender[4]	503	71.6	25.0

TABLE III. HYDRYLLIN IN ASTHMA WITHOUT INFECTION

Case	Sex	Age	Dosage Tablets Per Day	Relief	Side Effects
1	M	63	2	50%	none
2	M	60	6	100%	none
3	M	63	6	75%	none
4	M	63	3	75%	none
5	M	33	2	75%	none
6	M	24	6	none	none
7	M	57	4	75%	none
8	F	49	3-4	none	none
9	F	50	5	75%	none
10	F	46	8	none	none
11	F	26	4	75%	none
12	F	44	2	100%	none
13	F	44	9	100%	none
14	M	63	8	50%	none
15	F	27	1	100%	none
16	F	50	4	75%	moderate sleepiness
17	F	55	5-8	75%	nervous two hours later
18	M	63	6	no relief	moderate dizziness
19	M	40	3	75%	severe nausea; stomach pains
20	M	54	2	slight	severe nausea; nervousness
21	F	33	4	75%	severe nausea (pregnant)
22	M	27	6	75%	moderate sleepiness

nervous system, accounting for the commoner side reactions, chiefly drowsiness, seen with these drugs.

Keeping in mind the stimulating effect of aminophylline on the nervous system, it would seem that not only would a combination of aminophylline and benadryl be more effective in asthma, but the frequency of side reactions would be greatly reduced by the combination of the stimulating effect of one with the depressing effect of the other. Theoretically the addition of aminophylline to benadryl would be expected to decrease the incidence and severity of such reactions. The relaxing effect of aminophylline on the bronchial musculature would also seem to make this combination a particularly useful one in asthma. Such a combination has been prepared and is available under the name of Hydryllin.* Each tablet consists of 25 mg. of diphenhydramine (benadryl base) and 100 mg. of aminophylline. This combination has been used clinically in forty-seven cases.

Dosage

We prescribed, on the average, one tablet every three or four hours for relief of symptoms. In some of our milder cases one tablet per day was sufficient. Other patients took as many as eight tablets in twenty-four hours. Several patients took two tablets at once in order to obtain a sufficient degree of relief. It was noticed that generally if one tablet was not sufficient for relief, two tablets produced greater benefit. The drug was very prompt in action. Whenever it relieved the symptoms, it would do so in from ten to thirty minutes.

*G. D. Searle and Company, Chicago, Illinois.

TABLE IV. HYDRYLLIN IN ASTHMA ASSOCIATED WITH INFECTION

Case	Sex	Age	Dosage Tablets Per Day	Relief	Side Effects
1	M	33	6	none	slight dryness of skin
2	M	53	6-8	none	none
3	M	39	8-10	75%	moderate shakiness and dizziness

TABLE V. HYDRYLLIN IN SEASONAL HAY FEVER

Case	Sex	Age	Dosage Tablets Per Day	Relief	Side Effects
1	M	62	3-4	50%	none
2	F	26	4	75%	none
3	F	21	2	75%	none
4	F	45	2	75%	none
5	M	42	6	75%	none
6	F	25	3	75%	none
7	F	20	2	100%	none
8	F	23	4	75%	none
9	F	27	6	75%	none
10	F	13	4	75%	none
11	M	19	4	100%	none
12	F	39	6-8	75%	none
13	M	30	4	75%	none
14	F	41	4	75%	none
15	F	39	4	75%	none
16	F	53	3-4	75%	none
17	F	41	3-4	none	moderate sleepiness
18	F	49	4-8	75%	severe dizziness
19	F	52	4	none	severe drowsiness
20	F	47	4	75%	slight sleepiness
21	F	40	4	50%	taste in mouth
22	F	38	4	50%	moderate nervousness
23	F	44	4	none	slight drowsiness

Summary of Results

From Table III it can be seen that sixteen (72.5 per cent) of twenty-two patients who had asthma without complicating bronchial infection received relief of from 50 to 100 per cent. Such relief generally lasted about three to six hours after each dose of the drug. Six (27.5 per cent) received no benefit.

Three patients whose asthma was complicated by bronchial infection received the drug. Of these only one was appreciably benefited. It was also noted that a number of patients, whose asthma was previously relieved with the drug, failed to respond if a respiratory infection supervened.

The results in hay fever with hydryllin were very striking. Twenty of twenty-three seasonal hay fever patients (86.9 per cent) were markedly benefited, receiving relief varying from 50 to 100 per cent.

Side Reactions

There were sixteen patients in this series of forty-eight who exhibited side reactions of sufficient degree to be clinically important. This is a relatively low percentage (25 per cent) compared

to the side reactions reported from both benadryl and pyribenzamine.

It should be emphasized again that the antihistaminic drugs are palliative only, i.e., primarily for the relief of symptoms. They are extremely useful for this purpose. They do not obviate the necessity for complete allergic studies to determine the etiological allergens, nor do they act as a substitute for specific treatment of the allergic diseases, except in those milder cases exhibiting symptoms of short duration.

Conclusions

Hydryllin, a combination of diphenhydramine (benadryl base) and aminophylline has been evaluated clinically in forty-eight cases of asthma and hay fever. The results in both of these conditions are much better than with pyribenzamine or benadryl alone. The side reactions have been considerably less in number.

These observations are in the nature of a preliminary report. The drug has not been tried in a sufficient number of cases of urticaria, allergic rhinitis and atopic eczema to be included.

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469 Fisher Building

Certain Aspects of Vaginal Surgery

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SURGICAL PROCEDURES approached from the vagina are undertaken for the reconstruction of the structures supporting the canal, damaged by childbirth, the correction of congenital defects, the removal of pathological lesions or the removal of the uterus incident to reconstruction of the birth canal and pelvic floor.

I shall in this brief communication limit my remarks to the reconstruction of the damaged canal.

Whether apparent or not, all births, of necessity, to a degree damage the structures which support the pelvic organs. However, it is only when such damage is sufficiently extensive to give rise to persistent symptoms that patients seek relief.

As in surgery, and more particularly in vaginal surgery, "the anatomical mind is as essential as the aseptic conscience."

In the first place, it is not inappropriate to review briefly the anatomy of the pelvic basin with particular reference to those structures which maintain the topography of the pelvic viscera. There are many factors which contribute in part to the support of the viscera, not the least of which is *posture*. In early fetal life, or until birth, there are no demonstrable vertebral curves, but with the adoption of the upright posture, the vertebrae develops certain curves, namely the cervicodorsal and the lumbosacral. The purpose of these is to absorb shock which would otherwise be transmitted through the vertebrae to the brain. In addition to this function, the lumbosacral curve alters the direction of the pelvic canal by directing it in a more or less backward direction. By this inclination, the weight of the pelvic viscera is transferred from the pelvic basin onto the pubis, the rami and the so-called triangular ligament, and to a lesser extent to the pelvic diaphragm. Super-

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ficially, the perineal body is of very considerable importance as it forms the hub of the perineal musculature, and retains the normal topography of the caudal outlets.

The *pelvic diaphragm* is evolved from the muscles which, in the animal, are primarily concerned in manipulating the tail. This group of muscles arise from the pelvic wall and are inserted into the coccyx and the mid-raphe which, in effect, is the vestigial remains of the terminal segments of the tail. Coincident with the adoption of the upright posture and the disappearance of the caudal apparatus, these muscles have become fused and somewhat re-arranged into a composite muscular sheet, known as the levator ani, which in the human is now capable of giving a degree of support to the pelvic viscera.

Since the *levator ani* only partially closes the floor, there is left an aperture bounded by the medial borders of the *levator ani,* regarded as an anovaginal cleft which accommodates the outlets in this region of the body.

Peculiar to the human is a second or so-called *urogenital* diaphragm or triangular ligament which spans the pubic arch in order to support further the pelvic diaphragm previously mentioned. Like the pelvic diaphragm, this fibromuscular structure is composed of muscle with its enclosing fascia. It is perforated by the vagina posteriorly, and more anteriorly in that portion immediately beneath the pubic arch it is perforated by the urethra and the dorsal vein of the clitoris.

I should like to point out that all muscle is developed in mesenchymal tissue and the undifferentiated portion of it remains as fascia or an encasement of varying degrees of thickness enclosing that portion differentiated into muscle. It is for this reason that in vaginal surgery the fascial sheath of the particular muscle in question is of greater structural value than the poorly developed muscle which it encases.

Upon the floor of the pelvic basin and lying retro-peritoneally, is *cellular tissue* in which are embedded the pelvic organs. Throughout this cellular structure, which in the fetal state is abundant, are interspersed involuntary muscular fibers. It is axiomatic that when cellular tissue suspended between two fixed points is subjected to strain, it becomes condensed. These thickened folds or areas of condensation are dignified by the name of ligaments, of which there can be demonstrated the uterosacral, its opponent, the puboservical fascia, and certain thickened areas extending to the pelvic walls, demonstrated by Machenrodt and bearing his name. These cause the pelvic organs to return to their normal position after physiological displacement, but when stretched beyond these limits, subsequently do not regain their complete function. While no one structure in the pelvic basin can be said to support the pelvic viscera, the brunt of the burden is borne by this compact fibromuscular tissue in which they are more or less embedded.

Whatever the primary cause of displacement of the pelvic organs may be, it is quite apparent that pathological stretching or damage to this tissue (comparable to the hausers of a balloon) is responsible for the many displacements that one encounters.

Probably the most common symptoms referrable to the pelvis are pain in the back, urinary frequency, pain in the groin or in the vulva, or pressure on the rectum. In many instances these are due to retroversion of the uterus. Since at birth the uterus is extremely diminutive, so-called congenital retroversion exists in name only. In order that the uterus, which normally moves through a wide range, remain retroposed, the fibromuscular bed which supports the uterus must, of necessity, be subjected to some pathological force. I submit that the most common cause of retroversion is the habitually overloaded bladder in adolescence. In the parous, in addition to the relaxation coincident with pregnancy and delivery, there is a tendency to negelct the bladder during the puerperium. Under no circumstances may the cellular tissue supporting the pelvic organs be subjected to continuous or pathological strain. In the majority of instances no surgery is required for the correction of retroversion. By frequent *urination* (every hour on the hour) the cause is usually removed. Correction in *posture* and knee-chest exercises should be stressed in the puerperal case while the prone position several times daily and during sleep assists materially. The *pessary* is reserved as an adjunct to these measures following delivery and when possible as an aid to clarify the diagnosis. Let me, at this point, emphasize that the pelvic organs are supported from below and not suspended from above.

When the pubocervical fascia has been elongated by reason of a prolonged or obstructed second stage, it is obvious that it becomes pathologically stretched so that it does not easily regain its normal tone;

consequently, under such circumstances the bladder subsequently sags. The same is true if this structure becomes lacerated, but whether damaged from overstretching or laceration, scar tissue ultimately replaces traumatized tissue.

If after following such a formula, previously mentioned, the symptoms are improved, it becomes apparent that the retroversion of the uterus is responsible for the syndrome of which the patient complains. However, the following questions must be clarified;

1. Are the adnexa normal?
2. Are the symptoms solely due to simple retroversion, uncomplicated by relaxation of the structures which support the pelvic organs?
3. Or does the vaginal relaxation contribute to the malposition of the uterus?

In the latter instance, simple suspension is worse than no operation, for the support of the bladder is subsequently converted into a sort of hammock analagous to the "bas fond" encountered in the male with an enlarged prostate.

It is of more than historical interest that in 1831, Marshall Hall, animated by the history of a patient cured from contractures in the vagina following ulceration produced by the prolonged use of a pessary, decided to imitate this result by operation. Many and varied were the procedures advocated by the physicians, including escharotics, denudations or a combination of these with suturing. In any case, Marshall Hall may be considered the father of surgical repair for the reconstruction of the damaged birth canal.

Damage to the birth canal in the form of urethrocele or cystoceles, or a combination of both, is probably more common than is ordinarily recognized, and paradoxical as it may seem, follows upon an easy labor. This is mainly due to pelvic architecture.

Experience has taught us that it is impossible to repair one portion of the anterior vaginal wall without exaggerating the distortion of the remaining part. In repair of the anterior vaginal wall, therefore, whether for urethrocele or cystocele, the incision must be carried from the urethra to the cervix in order to expose the pubocervical fascia throughout the whole length, as well as the base of that portion of the urogenital diaphragm through which the urethra passes. In most instances of cystocele, the bladder has rather slipped down on the cervix so that it is necessary in the reconstruction to first replace the bladder by pushing it upwards on the anterior aspect of the uterus. When the bases of the broad ligaments are adequately exposed, they should be securely approximated anterior to the cervix, for in so doing, the uterosacral ligaments being indirectly thus shortened, the cervix is held high in the vagina while the fundus of the uterus is thrown forwards into its normal position.

In the extremely obese with a large apron, one is frequently disappointed by the persistence of urinary symptoms following what appears to be a satisfactory repair of the birth canal. The cause for such frequency does not lie in the defective support of the bladder or any pathological process in the urinary tract, but purely from the mechanical pressure of a diffuse lipoma of the anterior abdominal wall held against the bladder by a "tight-fitting" supporting garment. The patient can be completely relieved of her symptoms with a resection of the pendulous lipoma.

In reconstruction of the posterior vaginal wall, the operator must first determine whether or not the rectocele is due to relaxation of the perirectal cellular tissue, to destruction of the perineal body supporting the ampulla, or to both. If added to the relaxation there is descent of the base of the broad ligament recognized by the lower position of the cervix, one must bear in mind that in a large percentage of cases there may be a congenital defect in the rectovaginal septum, permitting a prolongation downwards of the pouch of Douglas. If such a condition is present, the so-called simple repair will not permanently correct the disability. In repair of the rectocele, the perirectal cellular tissue is approximated by a series of interrupted sutures commencing high up in the vagina. If the mucous membrane is undercut, no further suturing is necessary. In repair of the structure supporting the ampulla of the rectum (perineal body), it is not necessary to isolate the levator ani, but rather to draw together its fascial covering. In repair the perineal body is carried up as the recto-vaginal septum.

The superficial perineal musculature should be considered as the perineal platysma, and as such, maintains the topography of the vaginal and anal outlets. The sphincters surrounding these two structures therefore must be fixed to each other, for if not, the vaginal sphincter, not being anchored posteriorly, will naturally draw the skin of the

perineal area forward, producing a barrier to the vaginal outlet; similarly, the sphincter ani extermus not being held forward is drawn backwards, producing the most distressing symptom of a so-called "sacral anus."

The extreme degree of birth trauma is that in which the cervix descents through the vaginal outlet. Here all ligaments supporting the uterus and the pelvic organs are elongated to a pathological degree. Further, by reason of the descent, the pouch of Douglas is elongated. Certain procedures for the repair of rectocele or enterocele with moderate or even extreme descent of the uterus prescribe amputation of the cervix as an integral part of the technique. While under such circumstances a shortened cervix is desired, the method usually followed of conization and inversion of the mucous membrane is not without its disadvantages. If the cervix must be amputated this is very satisfactorily done with the actual cautery. To favor coagulation of blood vessels, the cautery should be kept at a heliotrope glow. The slough is only very superficial following such procedure, and the crater becomes perfectly epitheliated within three weeks. On the other hand, an inverted mucous membrane does not always "take" over the whole crater, so that several pockets develop which collect secretions. These become veritable cesspools, causing a constant or intermittent offensive malodorous discharge. Further, the absorption from such an area is reflected in tender broad ligaments and a general lack of well being.

In the diagnosis of enterocele, erroneously referred to as a high rectocele as distinct from rectocele *per se,* or the not infrequent combination of both, there are many methods devised, none of which are entirely satisfactory.

By employing the index fingers of both hands, that is, one in the rectum and the other vaginally, one is usually able to differentiate these two conditions, for by reducing the rectocele, the enterocele bulges above both the vaginal and rectal finger. It is quite essential that a differentiation should be made between these conditions for if the enterocele is not recognized, repair of a mistaken rectocele will give no relief.

An enterocele is a hernia, and in its repair the surgical principles for the repair of hernia must be applied. These consist essentially of obliteration of the hernial sac. In my experience when an enterocele is sufficiently distressing to warrant operation, it is best treated by vaginal hysterectomy. This procedure makes all the structures concerned more accessible and the results are extremely good. On the other hand, resection of the sac alone is not satisfactory, as the uterus is often drawn backwards and the final result leaves much scar which is apt to give the patient a sensation of a foreign body in the rectum.

Complete tear, is probably the most common and serious accident occurring during delivery. While, as in urethrocele, the cause may lie in an architecturally faulty pelvic outlet, many deep lacerations may be averted by the prevention of the premature extension of the head. Obstetricians, generally rather neglect to recognize the fact that care in the delivery of the shoulders is as important as that of the head. In brief, the anterior shoulder should be delivered while the posterior is held backward and under no circumstances should the child be delivered "broad on" so to speak with both shoulders crossing the perineum simultaneously.

In repair of complete tear, primary or secondary, the following points should be observed:

1. Preoperative care of bowels.
2. Remove all scars.
3. Isolate ends of sphincter.
4. Stretch sphincter.
5. No sutures through mucosa.
6. Suture muscularis to muscularis.
7. Suture sphincter to anal cuff.
8. Approximate perirectal tissue.
9. Suture vaginal to anal sphincter.

In the secondary repair, particular attention should be paid preoperatively to the toilet of the bowel, and the importance of a low residue diet for four days preceding operation should be emphasized.

Vaginal Hysterectomy

In general, I do not consider it a sound surgical practice to remove the uterus vaginally for indications for which the uterus is primarily concerned. On the other hand, if vaginal surgery is indicated and the uterus is not in a healthy state, providing (1) there are no pelvic adhesions, (2) no carcinoma in the cervix or body of the uterus, (3) no palpable lesion in the pelvis, and (4) if the uterus is not beyond the size of a six weeks' pregnancy, vaginal removal of the uterus coincident with repair is preferable to repair and abdominal hysterectomy. It is quite apparent that where

there is much destruction of the peritoneum due to the freezing of adhesions or the removal of extensive inflammatory or morbid processes, reperitonealization by the vaginal route will be in all instances difficult, in many unsatisfactory, and in an even larger number impossible. Let me again emphasize that benign lesions in a small uterus, for which vaginal hysterectomy is the procedure of choice, are not particularly common.

Vaginal hysterectomy with repair of the birth canal for varying degrees of procidentia has proven to be a satisfactory procedure. It is well, however, for us to remind ourselves of the causes of procidentia, as by so doing, one can forecast the result of such a surgical procedure. The causes of procidentia are:

1. Secondary to Birth Trauma:
   (a) Overstretching supports of pelvic organs.
   (b) Rectocele.
2. Weakness in the Musculature of the Pelvic Cellular tissue:
   (a) Inherent.
   (b) Subsequent to prolonged systemic infection.
   (c) From debilitating diseases such as:
      (1) Diabetes.
      (2) Pernicious anemia.
3. Congenital Defect in the Rectovaginal Septum.
4. Disturbed Innervation:
   (a) Spinal cord lesions.

There are three accepted methods for removal of the uterus vaginally. The principles involved are:

1. The broad ligament (so-called cardinal ligament) is employed to support the pelvic basin.

2. In the clamp method (Kennedy and Price) the cicatrix, following the removal of the clamps, forms a dense keystone of scar tissue, which prevents subsequent prolapse.

3. The uterosacral ligaments are so sutured into the puboservical fascia as to form a continuous fascial plain extending from the pubis to the sacrum.

The salient points, in vaginal hysterectomy by the ligature method are:

1. Securely obliterating the pouch of Douglas.
2. Exteriorization of bleeding points.
3. Reaffixing the uterosacral ligaments directly to the pubocervical fascia.

Inversion of the vagina following abdominal hysterectomy is treated surgically in a manner similar to that of vaginal hysterectomy.

The preparation of the patient for vaginal surgery is important.

Both local and systemic factors must be considered in the patient's preparation. Just as a great deal of success of the operation depends upon operating on relatively healthy tissue in as clear a field as can be prepared, so the safety of the procedure depends upon a careful preoperative regimen directed towards improving the patient's general condition.

All patients over fifty years of age, as well as those under fifty with any history of cardiovascular symptoms, should have an electrocardiogram taken preoperatively.

A blood urea estimation and a sugar tolerance curve should be done, for it has been found that a sizable number of these patients have a reduced sugar tolerance. When such is the case, healing is retarded and complications increased unless this reduced tolerance is combated preoperatively.

It is only by a preoperative knowledge of prothrombin time that the incidence of thrombophlebitis can be reduced. The timely administration of heparin and dicoumarol postoperatively, as indicated by prothrombin time, should reduce the hazard of emboli.

Patients showing more than eight white blood cells per high power field in a catheter specimen of urine should receive appropriate amounts of sulfonamides preoperatively if the causative organisms are sulfonamide-sensitive.

Upon completion of the clinical and laboratory investigation, the patient should be given three or four days of "preoperative convalescence." During this time, fluids, fruit juices, and milk are liberally given; rest is induced by sedation, and debilitated patients are given intravenous protein for at least twenty-four hours prior to operation.

The preparation of the operative field also demands attention. Senile vaginitis, such as is present in a great number of patients who are postmenopausal, is most inimical to primary healing. In order to avert delayed healing and infection, some estrogen preparation should be given by mouth in moderate dosage. Excessive estrogen therapy however, will produce a very friable and hyperemic mucosa which may present considerable difficulty in suturing.

During the preoperative period, lactic acid douches, one dram to the pint, will be found to

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Importance of Preoperative and Postoperative Care in Intestinal Surgery

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FROM THE BEGINNING, the greatest single factor in the cause of death in intra-abdominal operations has been infection. The same is true today! This statement has been confirmed time and again at autopsy.

During the past six or seven years, however, the morbidity and mortality rates in intestinal surgery have been reduced considerably. What is the reason for this? It is the opinion of my colleagues and myself that the employment of bacteriostatic agents and antibiotics is the answer. In the beginning, permit me to say that I am fully aware of the fact that the agents just mentioned have been used and are still frequently used empirically, and that many patients so treated undoubtedly would have recovered without their employment.

It is my intention in this presentation to emphasize the apparent effect of certain sulfonamides, penicillin and streptomycin, on patients who have undergone intestinal operations. Our over-all hospital mortality rate has decreased from about 15 per cent to less than 5 per cent (on the basis of patients, not operations) since the employment of sulfasuxidine (succinylsulfathiazole) prior to operation has become routine. As is well known, this sulfonamide is poorly absorbed by the blood stream. Its effect, as demonstrated by Poth and others, is to decrease appreciably the number of coliform organisms in the feces.

Until recently it was our custom to administer preoperatively to patients who were to undergo an intestinal surgical procedure a total of 720 grains (48 gm.) of sulfasuxidine over a seventy-two hour period. In addition, sodium phosphate was administered during the first twenty-four hours of presurgical preparation; gentle saline rectal irrigations were also carried out during this time.

During the past six months it has been my plan to administer about 1,200 grains (80 gm.) of sulfasuxidine over a period of eight to ten days prior to operations on the intestinal tract. This method of preparation, as a rule, makes unnecessary the use of catharsis and rectal irrigation because sulfasuxidine, in most instances, by its cathartic effect brings about emptying of the bowel. In a number of patients in whom resection of the bowel has been carried out, streptomycin in addition to sulfasuxidine has been employed in doses of 1 gm. per day (0.33 gm. three times a day) for two days prior to operation.

Poth and I independently have observed that streptomycin given in the manner just mentioned reduces the bacterial count per gram of wet stool from around 3,000,000 to 1,800. This tends to parallel the reduction of organisms in the bowel following the adequate use of sulfasuxidine. It is important and interesting, however, that the effect of streptomycin upon coliform organisms appears to be only temporary and that, regardless of the amount of streptomycin given, the fecal bacterial count will again rise to the initial count within three to five days. It therefore seems pertinent to rely on streptomycin only as an adjunct in those patients in whom, for some reason, an inadequate amount of sulfasuxidine has been administered. From the evidence at hand, it is important in operations on the intestine to keep the intestinal flora at a low count until healing has taken place and the postoperative danger period has passed. This is best achieved, according to our present knowledge, by administering by mouth 2 to 3 gm. of sulfathaladine (phthalylsulfathiazole) four times daily for six to eight days postoperatively beginning on the second day after resection.

What about unfavorable reactions following the foregoing regimen? According to my experience such reactions have been few indeed. There have been no renal complications. A few patients have been sensitive to sulfasuxidine. This was manifested by an erythematous type of skin rash. This minor complication can be overcome by the administration of para-aminobenzoic acid or by the subcutaneous administration of 10 to 30 c.c. of 0.5 per cent solution of procaine. The latter may have to be repeated if a single injection does not bring relief.

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The Intraperitoneal Use of Sulfonamides

Sulfanilamide was, for a time, employed in 5 to 10 gm. amounts at the completion of intestinal resections. In my opinion it has been demonstrated clearly that this sulfonamide is monovalent, whereas sulfathiazole is polyvalent. Sulfathiazole stimulates peritoneal response characterized by the appearance of large monocytic cells. These cells, as Rixford and I demonstrated after the intraperitoneal injection of mixed vaccine, are far more phagocytic than are polymorphonuclear leukocytes. Sulfanilamide employed in the peritoneal cavity, as Herrell has stated, is completely absorbed in twelve to twenty-four hours, whereas sulfathiazole apparently remains in the peritoneal cavity for about five days. Therefore it is my custom to place 5 gm. of sulfathiazole in the peritoneal cavity at the completion of a resection of the bowel.

The value of sulfasuxidine in intestinal surgery has recently been re-emphasized by Poth. He demonstrated, in intestinal operations carried out in dogs, that if an end-to-end type of anastomosis, open method, was employed after preoperative administration of sulfasuxidine for ten days, the site of the anastomosis healed rapidly, leaving only a faint hairline type of scar where the bowel ends healed. Microscopic studies of sections made through these sites of anastomosis were characterized by evidence of rapid formation of fibroblasts. A high mortality followed similar intestinal resections performed by the open method of end-to-end anastomosis when preoperative preparation with sulfasuxidine was not carried out, and in the animals that survived there was an ugly ulcerating scar at the site of the anastomosis. Microscopic study of sections cut through these scars revealed only a few fibroblasts.

Mesenteric Thrombosis Experimentally Produced

Poth further demonstrated in studies on animals that if sulfasuxidine was administered for ten to twelve days prior to ligation of the mesenteric vessels, 80 per cent of the animals survived. Extensive necrosis of the intestine was found at autopsy in the 20 per cent which died. By frequently opening the abdominal cavity of the animals that recovered (80 per cent), it was observed that marked venous engorgement of the intestine occurred and this was followed by formation of a plastic exudate; also it was noted that the life of the segment of bowel, and even the life of the animal itself, depended on rapid formation of blood vessels between the segment deprived of blood supply and an adjacent organ such as another segment of bowel or the omentum. At the time these animals were killed, the segment of bowel which had been deprived of its vascular supply appeared normal except that it firmly adhered to the adjacent normal structure previously mentioned. When similar experiments were carried out on animals without preparation with sulfasuxidine, 80 per cent died in four days because of extensive necrosis of the intestine.

Progress in medicine is slow, and perhaps it should be so. Many surgeons still are of the opinion that certain sulfonamide and antibiotic substances are useless or of no value, for example, in intestinal resections. Their cry is: If good technique is employed, good results will be obtained. According to my knowledge, all who are interested in surgery do not now, or never have, argued against good surgical technique; it is my belief that those who argue against the proper employment of bacteriostatic agents and certain antibiotics are viewing facts through jaundiced eyes.

MSMS

NAVY'S NEW MEDICAL PROGRAM

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with concurrence of the Specialty Board. Upon acceptance of the designated training, they will be required to agree to remain in the Navy for a certain obligated time.

If on original appointment a candidate has not been approved for more than one year of training, during his first year of residency training (Program A) he may compete for one of the 300 residencies (Program B) available to the Regular Naval medical officers, and if he obtains such training he will obligate himself to remains on active duty for an additional period depending upon the amount of time spent in training.

Program B: Three hundred residencies, fellowships or courses, will be reserved for continuing the Training Program as presently organized for regular medical officers.

The obligated service following graduate medical training (courses, fellowships and residencies) in Naval hospitals is one year for each year of training received.

Information concerning any part of the program may be obtained by writing to the Chief of the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

The Continued Education of Our Doctors

By George L. Schadt, M.D.
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WE ARE AGREED, and have been, since the pioneer research of Pasteur, Lister and others, that the continued education of doctors—general practitioners and specialists—is an absolute "must" in the progress of medicine if medicine, as an art, is to justify itself in the complicated and changing social pattern of today. It has been enunciated repeatedly that we either go forward or go backward—we never remain static. Change being the order of our day, change so rapid that it often times startles and dismays, makes necessary, therefore, continuous adjustments in the evolution of medicine as a whole, beginning with the preliminary education of the embryo doctor in the basic sciences, medical school teaching, hospital training and, finally, the practice of medicine itself in one form or another—the latter the ultimate goal of the great majority who eventually graduate as doctors of medicine and who practice the art.

My part in this discussion, I take it, is primarily concerned with the continued education of the general practitioner, though much of what will be said may apply to the specialist as well. Theories in diagnosis, laboratory developments, the swing from drugs to biotics and chemicals, hormones and vitamins in the treatment of disease, have undergone kaleidoscopic changes during the last several decades, changes that will eventuate further with the ever-expanding horizons of medical and chemical research, undoubtedly in a very large degree to the latter since atomic medicine is definitely on the threshold.

The important and pressing problem before us is, how best can we transmit these new and ever-changing developments, and how quickly, to the general practitioner and specialist as well, that each may, within the sphere of his activities make them applicable in his practice. It is this phase of the problem that shall now engage our attention.

As we sense it, the general practitioner problem today is not one, in a large degree at least, of urban areas, but rather suburban and rural. He works alone as a rule and, working alone, engages in practically every branch of medical endeavor—medicine, surgery (minor and major on occasion), obstetrics and gynecology, pediatrics, geriatrics, eye, ear, nose and throat, et cetera. He must, then, be kept abreast of these newer concepts in all fields of medicine found worthy by study and trial, and be supplied with these newer implements of his art; and ever and above all, he must be given them as near his particular area of activity as possible and at a time convenient for him to leave his ever-pressing responsibilities. These are very important considerations, worthy of our serious and immediate thought.

That these considerations in furnishing continued medical education to their members have been appreciated in a considerable degree by many state medical societies is evidenced by the rapidly increasing number of extension courses offered by them and other medical organizations. In my own commonwealth, Massachusetts, the third annual Postgraduate Lecture Course presented by the state society will be held bi-weekly from March 8 to May 5 at the Sanders Theater in Cambridge. At the same time, one-day extension courses are given yearly in a few of the eighteen district societies. Pennsylvania recently has inaugurated a series of one-day extension courses in six sections of the state. Connecticut conducts, yearly, a very successful postgraduate assembly, and in other states, New York, for one, the Academy of Medicine in New York City conducts many postgraduate meetings during each year.

Within the past several weeks, the American Medical Association conducted the first interim meeting in its history at Cleveland, solely for the benefit of the general practitioner. This meeting, we all hope, institutes a new era and a continuing one in the policy of our national association. These interim meetings should, in our opinion, be held in the different large cities of our country equipped to handle them, with an ever-increasing emphasis on medicine as practiced by the general practitioner in every section of our country. Perhaps the state societies will also profit from this step and themselves hold interim meetings in various sections of their respective states for the benefit of the general practitioner.

Read at the twenty-first annual meeting of the National Conference on Medical Service, Palmer House, Chicago, February 8, 1948.

Every medical school throughout the country has for many years conducted postgraduate courses of one kind or another, the great majority, however, concerned only with the training of physicians in the various specialties, though occasionally one finds refresher courses in medicine for the general practitioner—more so since the so-called end of World War II and the development of these courses for the returning veteran doctor. But is this enough? To be frank, we do not think so.

The problem under discussion is further complicated by the increasing desire of our doctors for board certification and, conversely, the insistence in some quarters that to attain staff membership, one *must* possess such certification, be it in medicine, surgery, pathology or any other branch.

The following editorial brief only recently came to my attention. The trustees of a prominent hospital near Boston as recently as October, 1946, made board membership or its equivalent an absolute requisite for appointment to its active staff. I quote:

"Hospital Change. Reaction to the high pressure tactics of some diplomates of specialty boards who apparently wish to keep all others out is making itself evident.

"At X hospital a trustees' rule made October 23, 1946, that new appointments to the active staff would be made only to internists certified by the Board of Internal Medicine or to members of the American College of Physicians or of a society of equivalent standing has been amended. The rule now reads, 'Appointments to the active staff on the medical service will be made only to physicians who practice internal medicine and have demonstrated a high interest in the scientific work of the Hospital.' The hospital is to be commended: why not extend this rule to all services?"

If conditions similar to the above were to prevail, then the future of the general practitioner in American medicine would certainly be sketchy in our opinion.

Where, may it be asked, will the general practitioner obtain the opportunity to see and treat large numbers of patients and thus gain the needed experience and growth in his profession? Denied staff appointment, what are the prospects for continued training and development?

For years without number, the general practitioner gained staff membership, gained experience in ward practice and eventually rose to service of his own, thereby becoming a better and more skilled practitioner in his locality. Is this order of things to be discarded as outmoded, penalizing thereby those members of our profession who prefer general practice to board certification and specialization? If so, then a large number of our colleagues stand to lose all opportunities for the study of disease, its varied manifestations and changing methods of treatment in case numbers large enough to permit worthwhile conclusions as to the effectiveness of methods employed. In our opinion one of the most important methods of continued medical education will be denied the general practitioner if experience in ward practice is lost to him by relegating to the past staff appointment and ward service. Denied these privileges, the general practitioner must, then, be provided with other opportunities for continued training in the newer advances in all branches of medicine.

Let us now consider the means at hand and means so far untouched, some with great potential possibilities in the education of our doctors—means and methods all adaptable to our purpose.

Realizing that fulltime teachers in our medical schools are in some degree already overburdened with undergraduate teaching, we are nevertheless of the opinion that an increasing and ever-growing obligation rests on the medical schools and their faculties to make their services more and more available for the continued training of the general practitioner segment of our profession. To some extent, schools and fulltime teachers have already contributed in their attendance at extension courses, in panel discussions and in live clinic instruction, though, unfortunately, much if not most of this is carried out at the medical school or at the teaching hospital adjacent thereto and somewhat rarely, if ever, in sections of the state that make it convenient in time and with minimum expense to the general practitioner. We are of the opinion that by means of co-ordinated effort between medical schools and medical societies, the talents of our outstanding teachers in medicine might well be made increasingly available in panel discussions and in grand rounds in the hospitals in various sections of each state for the members of the profession in that locality and particularly for the general practitioner. Surely there are enough medical schools with many great teachers on their faculties throughout the country so that a plan of this type might well and easily be developed and put into action.

The above remarks apply also to the fulltime doctors in many of the larger hospitals throughout the country, men of great medical scholarship and

teaching ability. It is conceivable, for instance, that a plan might be developed in that, from time to time and on a regular schedule during eight or nine months in the year, these teachers could spend a day on service at a hospital in different cities throughout the state, making grand rounds, holding clinics, et cetera.—the day's activities well publicized and open to all practitioners in the neighborhood.

The employment of local doctors in teaching local groups, except in the larger teaching centers, is, in my opinion, a questionable one though at the present time a course employing local doctors in teaching graduates of unapproved schools is being conducted in one of the counties in Massachusetts and is most successful. It has been demonstrated repeatedly that the popular postgraduate courses are those given by men of wide experience and teaching ability, regardless, too, of the age of the instructor.

We are all familiar, of course, with the regular annual meeting of the American Medical Association. All our state medical societies hold excellent annual meetings, though all too often in the same large university city, one, in many instances, not centrally located and many miles from the habitat of many of the general practitioners. Our district societies, some of which are very active, hold monthly meetings, some less often. It would seem that more might well be done in the way of one-day extension teaching on a regular monthly or bi-monthly basis by our district or county societies, individually or in groups. Four adjacent county societies in one state organized some years ago a "Four County Medical Society" along these lines which has held some highly interesting and instructive one-day seminars or symposia with panel discussions on pertinent and timely subjects for its members—the average attendance, by the way, being 250 out of a possible 500, and practically all general practitioners.

The organization of postgraduate instruction, not always held in the larger city of the state but in some of the smaller communities, would, again, make it much easier and less expensive in time and money for the general practitioner to attend. It is desired at this point to emphasize once more that the continued education of our doctors should and must be made less expensive and less time-consuming for them. In other words, the Pennsylvania plan may well be employed, whereby full day extension courses would be given regularly in a large number of districts or groups of districts in each state, at least once a month or more often. As in Pennsylvania by popular demand, we should bring the mountain to Mohamed.

Now let us consider for a moment other and, in some cases, newer methods.

We have been impressed for years with the magnificent scientific exhibit presented at the annual meeting of the American Medical Association, regretting that it was available for study such a short time. It is well known that about eight to ten thousand members and fellows attend these meetings, a larger number this year in Atlantic City at the centennial. This represents approximately 7 to 10 per cent of the membership which is thus privileged to gain the advanced knowledge provided by these exhibits. Would it not be practicable to formulate some plan so that at the close of each annual meeting a certain number, say ten or twelve, of the most outstanding scientific exhibits could be brought together and sent for loan exhibit purposes to the different cities and towns that a greater percentage of our members might have an opportunity to see them during the following year? It is pleasant to visualize the possibility of a number of such highly educational collections touring throughout the nation between annual meetings, bringing the newer knowledge of diagnosis and treatment of disease to our general practitioner quickly and effectively. Expensive? Possibly, but self-supporting since the expense could well be pro-rated.

We are of the decided opinion that the movies have exceptional potential possibilities in postgraduate medical instruction. This method has hardly been scratched.

Our friends in the pharmaceutical profession have accomplished wonders with its use. It has been used extensively in teaching surgical technique. We have yet to see many, if any, movies in color and sound devoted to the presentation of medical subjects. If prize fights and sports of all description can so be presented, why not medical clinics from our larger and important teaching centers, demonstrating technique in the medical field—anemia, cardiac disease, dermatology, et cetera—diagnostic and therapeutic procedures. Such films would need subsidies, by the American Medical Association or government, or quite possibly our pharmaceutical friends might be interested.

The possibilities are tremendous and only need exploitation. Visual instruction and auditory instruction have gained considerably over the written page, and no more so than at the end of a long, arduous day of medical practice.

The radio also offers endless potential possibilities, as yet hardly touched except from the public health standpoint. It should be possible, in the very near future, for the busy doctor to listen to a paper presented by one of our many medical greats from any of our larger centers on any one of many subjects. Let us look into these possibilities.

We are all familiar with how easy it is to purchase an album of four or more records of a favorite symphony, excerpts from an appealing opera, songs by Crosby or Sinatra. Can you as easily, or at all, purchase an album of records to hear the voice of one of our great teachers discussing cardiac arrythmias, the new treatment of diabetics, or pernicious anemia, or hear a panel discussion by four outstanding authorities on gastric ulcer? Of course not, since as yet we have done nothing to develop this limitless field.

What general practitioner would not grasp eagerly at the chance to collect a library of such albums—the voices of known and respected authorities—that he could consult as often as he desired, at his home or office, at his leisure. (We hardly think that Mr. Petrillo would object to this kind of singing.)

We hesitate somewhat at the next statement. However, if our government can subsidize the farmer, the baker, the candlestick maker, why not subsidize, also, the humble private practitioner of medicine for a month's postgraduate course every three or five years? The cost would be trivial, the results tremendous, to a government demanding incessantly better medicine, socialized medicine, cheaper medicine.

In the final analysis, then, the continued education of our doctors requires the utilization of all the methods of postgraduate instruction now employed, plus an active and intelligent expansion of available facilities in all of them—especially the increased employment of teaching groups from medical schools, training hospitals, clinics, et cetera, including board men on full time in the larger nonteaching hospitals throughout the land.

Further, there should be immediate development of new methods—radio, movies, record albums, and some plan for making accessible to all our doctors the opportunity to profit from the worthwhile teaching afforded by exhibits, on tour, from the scientific sessions between annual meetings of the American Medical Association.

In conclusion, may we stress again and again, the opinion that to be increasingly effective, continued medical education must be brought to the general practitioner at a place and a time that will conserve his time, his finances and, above all, his energies—energies so needed for the arduous duties of his ever-busy day.

MSMS

ABDOMINAL SINUSES AND FISTULAS

(Continued from Page 853)

of ulcerative colitis, unless there is an intact rectum and anus to which it can be joined, has no satisfactory means for elimination.

Tuberculous abdominal sinuses occasionally heal under local injections of tuberculin in doses large enough to produce an intense reaction.

The great majority of abdominal sinuses and fistulas are now curable, in most cases, by operation.

VAGINAL SURGERY

(Continued from Page 875)

produce a cleaner operative field and reduce the number of pathogens present.

In vaginal surgery herein discussed, no matter what structures are repaired or removed, the aim is to preserve or restore the normal topography. The organs remaining or reconstructed should function without discomfort, and the patient's general well-being should be improved by the particular procedure employed.

In general, vaginal surgery should be undertaken only by those who are thoroughly familiar with pelvic pathology and all its ramifications, and who possess in addition a thorough working knowledge of the anatomy, topography, and so-called dynamics of the female pelvis. Moreover, upon contemplating the more extensive procedures, e.g., a vaginal hysterectomy, the surgeon must assess his own dexterity and take cognizance of his limitations; furthermore, he must consider the efficiency of his assistants and the circumstances under which he is operating.

Bon Secours Hospital Clinic Day

Session of June 8, 1948

Abstracts of the papers presented on the program of Bon Secours Hospital Clinic Day, June 8, 1948, are presented in the following pages.

STERILITY IN THE FEMALE
Clifford B. Loranger, M.D.

General history: Important—family fertility.
Sexual history: Normal performance of act.
Menstrual history

Examination

General: Obesity, thyroid (BMR) anemia, tuberculosis and syphilis

Pelvic: Infection, position of uterus; size of uterus—cervicofundal proportion; endometriosis—in women not pregnant for five years; cervical infection and secretion; tubes and ovaries.

Specific Tests: Vaginal smear. (Mack, papanicolaou); Huhner postcoital cervical; Kurzok 2 drop test; tubal insufflation—postmenstrual; endometrial biopsy—premenstrual; temperature cycle; pregnandiol in urine, premenstrual.

Treatment: General health; cervicitis; alkaline douche; thyroid; stilbesterol; vitamin E.

Barren Marriage

Sterility is assumed to be present after two or more years of marriage in which contraceptives were not used. About 10 per cent of all marriages are barren; Lotka says one in eight.

Social Factors: Effect on (1) welfare of society in general; (2) stability of the home; (3) happiness of the individual partners.

Answer this question: Is it for the good of society and for the couple that they have children? A question of inferior protoplasm must be interjected. Many pregnancies resulting from these sterility studies result in abortions and ectopic pregnancies.

Barren marriage is the result of the sum total of several factors—often minor—in both partners. Co-operation of husband must be secured before starting study.

GASTROINTESTINAL CASE PRESENTATION
Richard C. Connelly, M.D.

The case history of a woman of forty-one years who died in the second episode of massive hemorrhage from the upper gastrointestinal tract is presented. Slides show roentgen and autopsy findings.

The causes of massive hemorrhage into the upper gastrointestinal tract are enumerated and differential diagnosis discussed.

Treatment of the above case and of similar cases are given.

EMERGENCY TREATMENT OF DIABETIC COMA
T. H. Heenan, M.D.

1. Regular insulin, 75 units stat.
2. 500 c.c. 5 per cent glucose intravenously with 50 units of regular insulin in the solution, stat. and q. 4 h.
3. Urinalysis q. 2 h. for sugar, give regular insulin as follows:

If the urine is 4 plus give.....30 units.
If the urine is 3 plus give.....20 units.
If the urine is 2 plus give.....10 units.
If the urine is 1 plus give..... 5 units.
If the urine is negative give..... 0 units.

4. Feedings q. 2 h. consisting of milk 150 c.c., alternating with orange juice 150 c.c.
5. 1000 c.c. saline hypodermocylsis.
6. S. S. enema stat.
7. Gastric lavage, if vomiting is present.
8. Extra blankets and hot water bottles.
9. Ephedrine sulfate gr. 3/8 g. h.

DIAGNOSIS OF THE MORE COMMON TYPES OF CONGENITAL HEART DISEASE
Hugh Stalker, M.D.

Symptoms and signs of History, Observation, Auscultation, Electrocardiogram, and X-Ray of:

1. Interauricular septal defect.
2. Interventricular septal defect.
3. Patent ductus arteriosis.
4. Tetralogy of Fallot.
5. Eisenmenger's complex.
6. Coarctation of the aorta.

ARTIFICIAL KIDNEY
William E. Abbott, M.D.

The indications for employing an artificial kidney and the technique of the two available methods were discussed.

A presentation of the solutions which have been used were made and the problems and relative merits were emphasized.

The discussion was closed by presenting a summary covering the following problems.

1. The proper selection of cases.
2. When should therapy be started?
3. What methods and what solution should be used?
4. The methods of guiding treatment and caring for the patient.
5. Results of such therapy.

GLOMERULONEPHRITIS

James R. Marshall, M.D.

Formerly listed under the classification of Bright's disease. True causation still poorly understood in spite of over 100 years since Bright first described the disease.

Volhard believes it is caused by vasospasm of arterioles and is only part of a generalized systemic disease. Possibly protoplasmic shock. Popular theory at present is that the disease results from an allergic reaction between streptococcus toxins and kidney protein.

Pathology.—Diffuse endocapillaritis involving glomeruli and secondarily, the tubules. General ischemia of kidneys. Proliferation of endothelial cells of capillaries and epithelial cells of Bowman's capsule.

The disease most commonly affects young people and usually develops in from 7 to 14 days following acute infections of the upper respiratory tract of hemolytic streptococcic origin.

Subacute glomerulonephritis is differentiated as an accelerated form of chronic disease resulting fatally in from a few months to several years.

The chronic form may be present for many years without seriously hampering the individual's activity.

Diagnostic criteria: Findings of albuminuria: granular casts, and red blood cells in centrifuged fresh specimens.

Addis sediment count. Dark smoky urine. Oliguria or anuria.

Urine should be examined in all postinfection cases at intervals of seven, fourteen, and twenty-one days. Whenever possible urine should be examined in early stages of infectious disease to rule out previous existing nephritis.

Importance of early diagnosis is stressed. Many cases show no manifest symptoms of pallor, edema, et cetera.

Prognosis.—Complete recovery about 75 per cent, death in acute stage 5 per cent, carry over to chronic stage 20 per cent. Addis concludes that the future of the patient is decided in first week of disease.

Death usually from renal insufficiency or cardiac failure.

Treatment.—Adequate treatment and follow-up of all acute streptococic infections as prophylaxis. Complete bed rest in acute stage. Low protein diet and low fluid intake for first few days. Later liberal proteins and fluids. Encourage diuresis with mild alkaline fluids, no mercurials.

Watch for cardiac failure. May develop rapidly in acute stage. Antihistaminic drugs have not yet proved valuable but possibly should be tried in very early stages of acute disease.

Hygienic living and avoidance of infections, plus symptomatic treatment for the chronic cases.

CHRONIC PYELONEPHRITIS

William R. Flora, M.D.

Pyelonephritis.—A bacterial infection of the kidney in which both the pelvis and renal parenchyma are involved.

1. *Etiology*
   (a) Hematogenous
   (b) Ascending
   (c) Direct from Intestinal Lymphatics

2. *Predisposing Factors*
   Obstructive Lesions

3. *Bacteriology*
   (a) B. Coli—most frequent
   (b) Staphylococci — most of remainder — usually hematogenous
   (c) Streptococci
   (d) Proteus Vulgaris
   (e) Pseudomonas Pyoscyaneus
   (f) Aerobacter Aerogenes (et cetera)

4. *Pathological Findings*
   (a) Primarily interstitial tissue involved.
   (b) Glomerular and tubular nephritis.
   Pyelonephritis.
   (c) Relationship of pyelitis to pyelonephritis.
   (d) Changes vary with organism.
   (e) Microscopically
   Scattered patches extending from capsule through medulla to pelvis.

5. *Symptoms*
   (a) Acute Pyelonephritis—clear cut.
   (b) Chronic Pyelonephritis—not clear cut.
      1. Acute exacerbations periodically
      2. May be no constitutional symptoms
      3. May be only symptoms referable to urinary insufficiency
      4. May be only asymptomatic pyuria
      5. Edema and hypertension occur but not an important part
      6. N.P.N. elevated; P.S.P. reveals reduced function
      7. Complaints Recorded
         Abdominal Pain 8 x
         Lumbar Pain Conspicuously Absent
         Dysuria 1 x
         Dyspnea 7 x
         Edema 6 x
         Nausea and Vomiting 5 x
      8. Clinical Course in 22 cases
         All had renal findings
         Blood pressure normal in 14
         Blood pressure elevated in 8
         Specific gravity abnormal in nearly all.

6. *Treatment*
   (a) Disease always starts acute usually with clear-cut symptoms.
   (b) Bacterial infections of kidney must be diagnosed early.

(c) Must treat acute disease vigorously.
(d) Treatment of chronic pyelonephritis is prophylactic.
(e) Foci of infection.
(f) Removal of obstructive lesions if possible.
(g) No outstanding cures achieved with any drugs in chronic condition.
(h) Inform symptom-free patient of importance of periodic examinations.

Rh FACTOR IN PREGNANCY

Robert G. Swanson, M.D.

I. The incidence of Rh negative pregnant women averages about 15 per cent, but only about 3 per cent of all Rh negative women have Erythroblastosis fetalis.

II. Suggested clinical survey for all pregnant women:
A. Test all mothers for Rh factor;
In Rh negative mothers check husband and previous offspring;
B. Test for antibodies in multigravidas and primigravidas with history of previous transfusions;
C. Take a careful history for—
(1) Previous blood transfusions of unknown type.
(2) Whole blood given in the buttocks.
(3) Previous abortions—was curettement done?
(4) Previous labors and births—Caeserean section? Manual removal of placenta?
(5) Previous births—jaundice? anemia?

III. The value of antibody determinations.

IV. The prenatal course and conduct of labor and delivery:
(1) Desensitization—Ethylene disulfonate (Allergersol.)
(2) Termination of pregnancy prematurely.
(3) Choice of analgesia and anesthesia.
(4) Observe size of placenta and color of amniotic fluid.
(5) Emergency blood transfusions—alkalinize with sodium lactate I.V.

V. Role of the Rh factor in—
(1) Abortions
(2) Toxemias of Pregnancy.
(3) Premature placental detachment.
(4) Hydramnios.
(5) Malformations.

ENDOMETRIOSIS IN A GENERAL SURGICAL PRACTICE

Galen B. Ohmart, M.D.

Endometriosis is frequently encountered in a general surgical practice. It has been defined as a pathological condition in which living tissue resembling endometrium is found outside of the lining of the uterus.

There are two types of endometriosis, the internal, which is confined to the body of the uterus, and the external, which is usually found in the pelvis but may be found in other parts of the body. It is the external type of endometriosis which clinically closely resembles cancer in that there is a rather rapid growth with invasion and metastasis, thereby frequently producing pain, making many women semi-invalids.

It occurs in women of the child-bearing age accounting for ten per cent of all pelvic pathological conditions found in them.

It is frequently associated with or diagnosed as appendicitis. It is a common cause of obstruction of the small bowel and frequently produces symptoms of the sigmoid, which simulate carcinoma.

Radical surgery always cures these patients but inasmuch as it is often desirable to preserve the child-bearing function of these women less radical surgery should be done if possible. Each case must be judged individually on the findings at operation.

CONTACT THERAPY IN THE TREATMENT OF CARCINOMA OF THE LARYNX

Bruce Proctor, M.D.

1. A new method of treating certain cases of carcinoma of the larynx is submitted; namely, the use of low voltage radiation therapy at extremely short anode-surface distance.

2. In view of the multilating effects of total laryngectomy any new method of attack to preserve the larynx deserves and should be given the most careful consideration and clinical trial.

3. Caustic doses of radiation therapy can theoretically be delivered to carcinoma of the larynx, with or without excision of tumor, with a minimum degree of disturbance to the laryngeal physiology.

4. Caustic doses of x-ray therapy can be delivered in one treatment lasting only a few minutes at the time of laryngofissure.

5. The serious sequelae of deep x-ray therapy are minimized in the use of contact therapy.

6. With the use of contact therapy in addition to laryngofissure we hope to decrease the number of necessary total laryngectomies. With this technique we also hope to reduce the incidence of recurrence in that group of cases ordinarily treated by surgical excision at laryngofissure.

7. We eventually plan to use contact therapy alone without surgical excision in the treatment of superficial intrinsic carcinomas of the larynx following exposure at laryngofissure. In such cases better permanent voice may result.

TREATMENT OF FRACTURED JAWS

Gordon R. Maitland, D.D.S.

The method of treating fractured jaws has changed in the past twenty-five years. This is due to better hospital training in the field of oral surgery, to more simplified maxillary appliances, and to recent discoveries in the field of chemo-therapy. All these have helped to prevent and control osteomyelitis, that was so frequently seen in compound comminuted fractures of the jaws.

With lantern slides, an attempt was made to show different types of fractures and the method of treatment used in order to obtain and establish as near normal occlusion as possible.

The role that diet plays in the treatment of fractures was stressed.

ROENTGEN ASPECTS OF POLYPOID LESIONS OF THE COLON

W. George Belanger, M.D. and
E. Frederick Lang, M.D.

Following a brief introduction and review of symptoms, the roentgenological diagnosis of these tumors by barium and air contrast enemas, together with adjunct such as pressure and spot roentgenograms, was discussed. A number of cases of polypoid lesions of the colon were presented, and these were amplified by slides.

OCULAR DISTURBANCES AND HEADACHES

Cecil W. Lepard, M.D.

Those ocular disturbances which cause or contribute to headaches are far more common in the middle decades of life than either the early or later years. Refractive errors, muscle imbalance and astigmatism are among the most common findings and it is a rule that the slight degree of these abnormalities are most likely to cause symptoms. High refractive errors and strabismus are among those least likely to cause symptoms. In children under ten, headaches are rarely the result of ocular disturbances. In adults past fifty, glaucoma primary or secondary, iritis and ocular neuralgia are conditions most commonly met with.

Poorly fitted frames, poorly centered lenses or astigmatic lenses with an off axis may undo the work of a careful refraction. There is no substitute for a complete examination which should take into account the possibilities of visual correction, muscle balance and examination of the fundus, in determining the causes of the patient's complaints.

VAGINAL HYSTERECTOMY

Ira G. Downer, M.D. and
Donald H. Sweeny, M.D.

The purpose of this discussion is to emphasize the present-day attitude toward the value and scope of vaginal hysterectomy as compared with abdominal hysterectomy. Many excellent surgeons are conservative in their opinion toward indications for this procedure, and it is not widely followed because of the incomplete knowledge of the approach in the hands of most operators. The abdominal approach may appear easier to the surgeon, but the patient often benefits more from the vaginal approach. Personal results have been gratifying, both as to mortality and morbidity, as well as postoperative follow-up.

The evidences of vaginal hysterectomy; less operative shock, pelvic floor repair can be combined with extirpation of the uterus, decreased postoperative pain, always eliminates abnormal cervix, obesity does not interfere and cosmetic appearance.

Indications for vaginal hysterectomy depends upon the surgical skill of the individual operator. Procidentia is not the only indication.

Technique of vaginal hysterectomy should be straightforward anatomical approach, with the avoidance of clamps, careful hemostasis, necessary surgery to the adnexa, adequate support of the vaginal vault without dead space, peritonealization of raw areas and adequate drainage. (Slides of statistical data, anatomy and operative technique.)

CRUSH SYNDROME

Joseph A. Kasper, M.D.

In September, 1940, during the bombardment of London, it was observed that persons whose lower extremities had been subjected to prolonged pressure by fallen timbers, stones, et cetera, upon admission to the hospital at first appeared to be in fairly good condition, giving rise to no immediate concern. After several hours, however, those with extensive lesions developed swelling of the tissues in the damaged areas due to the accumulation of plasma in the extravascular spaces of the injured parts, and a corresponding reduction of blood volume. Oliguria or anuria developed in all of these cases, of which approximately 60 per cent died of uremia within several days. In March, 1941, Bywaters and Beall reported these observations in their first paper on "Crush Injuries." The development of anuria or oliguria in crush injuries is now known as the "Crush Syndrome." The essential experimental findings of Trueta and co-workers, who made studies in an effort to explain this syndrome, will be discussed. Conditions, other than crush injuries, in which it may be encountered will also be considered.

SOME HISTORICAL ASPECTS OF PSYCHOSOMATIC MEDICINE

Leo H. Bartemeier, M.D.

The psychosomatic concept is not new. It was first formulated by German physicians more than a century ago. The revival of interest in psychosmatic medicine during the recent years is the natural outcome of what psychopathology has learned, what physiology has taught us and the effort to find a solution for the diochotomy of body and mind. The aim of this concept is a unified approach to clinical problems.

Detroit Physiological Society

Sessions of April 15 and May 27, 1948

Session of April 15, 1948

Studies on the Newcastle Disease Virus (California Strain)

A. R. Taylor, Parke, Davis Research Laboratories

The infectious agent responsible for Newcastle disease of fowls has been concentrated and partially purified by means of ultracentrifugation. Studies of the biologically active concentrates have been made using electron microscopy, analytical ultracentrifugation and chemical analysis in an attempt to learn something of the physical, chemical and morphological characters of the virus.

The virus in freshly prepared concentrates in saline media appears to be a sperm-shaped particle with a head portion about 70 mμ in width and 180 mμ in length. The thin "tail" is quite variable in length but averages about 500 mμ. Well defined internal structure is observable in the head piece. Virus concentrates prepared from formalinized infectious chorioallantoic fluids, however, are comprised of essentially spherical particles of widely varying size. Very little evidence of lobulated, tailed structures was observed. Chemically the virus consists of protein and lipid in association with a small amount of nucleic acid.

Application of the Chromatographic Technique to the Determination of Fumaric Acid in Biological Materials

Lawrence M. Marshall,* James M. Orten, and Arthur H. Smith (Department of Physiological Chemistry, Wayne University College of Medicine).

The importance of fumaric acid as a metabolic intermediate in the "citric acid cycle" has become well established during the past few years. Progress in this field has been retarded, however, by the lack of a reliable quantitative method for the determination of fumaric acid and other related organic acids of the "citric acid cycle" in biological materials. This report presents a new method which has proven satisfactory in our hands for the determination of the small amounts of fumaric acid occurring in the tissues of the rat and which, in preliminary studies, gives promise of being equally applicable to the simultaneous determination of succinic, malic, citric, and perhaps other organic acids.

The method employs the "column partition technique" of Martin and Synge using silica gel to support a non-mobile aqueous phase containing the fumaric acid to be determined. The fumaric and other organic acids are then distributed into a mobile non-aqueous phase (amyl alcohol-chloroform mixture) according to the classical distribution law so that complete separation of the organic acids may be accomplished. The effluent acids are then determined by titration with 0.004 N NaOH. Recovery studies have established the quantitative applicability of the method to the determination of fumaric acid in rat tissue extracts. The specificity of the method was established by experiments in which a number of other organic acids were added, individually or in groups, to solutions of fumarate. No interference resulted.

By this method, the fumarate content of samples of the pooled tissues of twelve adult fasted rats was determined. The following average concentrations (in mg. per 100 gm.) were found: brain, 15.0; kidney, 9.5; liver, 7.8; muscle, 2.3; blood, less than 0.3.

The foregoing data thus indicate that there is a significant amount of fumaric acid in the tissues of the rat, particularly in brain, and furnish analytical support for the current concept of the importance of this member of the "citric acid cycle" in metabolic processes.

*National Institute of Health Research Fellow, 1947-48.

Session of May 27, 1948

The Use of Radioactive Isotopes in Medicine

K. E. Corrigan and Henrietta Hayden, Harper Hospital, Detroit.

The medical use of radioactive isotopes depends upon two facts—one, that the physiology and chemistry of these elements is in all ways identical with that of the non-radioactive element; second, that these elements can be specifically detected and measured with instruments like the Geiger counter. All of the elements of the periodic

(Continued on Page 937)

Responsibility

Twice in a week we were urged to give immediate and active support to independent groups of physicians who are trying to do a job for organized medicine. While the intentions of these groups are commendable, we doubt that their existence is either necessary or advisable.

The greater the number of groups who are responsible for a given work, the less likely is the work to be done well. Division into groups is necessarily followed by divided leadership, divided responsibility, divided interests, uncorrelated methods of approach, and loss of effectiveness.

The work of organized medicine should be done by organized medicine. To our minds this means the American Medical Association and its constituent State and component County Medical Societies. This should be the only group authorized to speak for organized medicine in matters pertaining to policy and public relations.

We have been told that because of its Articles of Incorporation, the American Medical Association can deal only with educational and scientific problems. In these fields it has set an enviable record throughout the years. We have been told, also, that it cannot take action on socio-economic questions. If this be true, the American Medical Association should be reorganized so that it can speak authoritatively on all matters that concern jointly the welfare of the public and the interests of the 140,000 Doctors of Medicine who are its members.

Let's give our wholehearted support to the American Medical Association and demand in return the type of leadership and initiative that we have a right to expect.

P. L. Ledwidge

President, Michigan State Medical Society

President's



Page

Editorial

EIGHTY-THIRD ANNUAL SESSION

THE EIGHTY-THIRD Annual Session of the Michigan State Medical Society will be held in Detroit at the Book-Cadillac Hotel, September 20, 21, 22, 23, and 24, 1948.

The House of Delegates will convene Monday morning, September 20, at 10:00 o'clock and will hold two meetings that day, also two meetings on Tuesday, September 21.

The General Session, the Scientific Assemblies, will start Wednesday, September 22, and continue through three very busy days. There will be seven general assemblies, thirteen section meetings, and twenty-two discussion conferences.

The General Assemblies will be addressed by twenty-eight of the highlight medical men of the nation. One Michigan man will be on the speakers' list. This tentative program was published in the June issue of THE JOURNAL.

No program ever attempted by the Michigan State Medical Society has held more of promise. None ever has deserved a better attendance.

This is the doctor's holiday and his recreation. We look for you. Meet old friends; make new ones. Learn the very latest progress in your swiftly moving science. Keep abreast of your profession and your peers.

TAKE-HOME PAY

EMPLOYES OF INDUSTRY, especially, and most employed people refer to their income as "take-home pay." Before the war they used to consider their salaries or wages as so much per hour, per week, or per year. That was the basic pay which they received. But when the income tax law was extended to cover almost everybody, and approximately 20 per cent deduction was made each pay day, workers began to talk about "take-home pay," and that was the money they received after deductions for income tax, for social security, for old age benefits, for insurance, for health protection, for community fund donations and for union dues. After these deductions are made, the amount the worker takes home for the support of his family, for housing and to provide a stake for the future is actually his income.

We have recently seen a report showing that the average weekly take-home pay for a family of four, the worker and three dependents, is now about $59.00, whereas in 1939 it was $23.50. Labor argues that this $59.00 payment, if reduced to the value of 1939, would be only about $34.50. Therefore, their increase in earnings is actually less than 40 per cent, and the earnings of industry during this same period have increased five times what they were. The figure used for industrial earnings is that published by industrial companies and organizations showing the gross "profit less taxes." This is not a proper amount for comparison because industry, in order to keep advancing, must put money back into its operations, must set up reserves in order to provide jobs for the workers.

The amount which industry should consider, which the stockholders and bondholders must consider, and employes should consider, is the amount paid in dividends. That is the only item which benefits the stockholders. The amount of earnings or profits, over and above the amount paid in dividends, truly augments the value of investment, but most of it goes to providing more jobs and better working conditions for the worker. In 1939, it took $2,000 capital investment to provide one job, now $8,000 is needed.

This new concept of income should have some significance for professional men. We have always considered our income as the gross receipts. That is fallacious. In later years, some of us have been basing our estimates on the net income—but there is no net income until all fixed or determined charges are deducted.

We should always consider income as "after taxes." We should not forget that in 1939 a net income of $15,000 yielded $14,169 to the taxpayer. In 1947 a net income of $15,000 left only $10,730 for the taxpayer, and the new 1948 tax law will leave $11,106. In 1939 a $25,000 net income left $22,673, but now to have approximately the 1939 useful income would require a net of $40,000, leaving the taxpayer with $23,014 after paying his income taxes.

Let's face realities and compare our professional income with the balance we would have if we

classified them the way the industrial workers do. Much has been said about the inflated incomes of the medical profession in these boom days. What does a doctor have to earn to realize the approximate $10,000 or $23,000 mentioned above? Various surveys show that it costs a doctor over 40 per cent of his cash receipts to carry on his business. Assuming an operational expense of 40 per cent, the man netting $10,000 after taxes would have to take in a gross of $25,000, and the man in the higher bracket would have to take in a gross of $67,000. But we are getting dizzy. How much of our dollar do we keep? Whatever it is, that is our "take-home pay." (The $25,000 man saves 44 cents out of his dollar, and the $67,000 man saves, 34.5 cents.)

MEDICAL CARE SECTION

A COMMITTEE has been appointed and has circularized many medical leaders for the creation of a Medical Care Section in the American Public Health Association. To quote from the Committee's letter, "It has been brought to our attention that there is at present no formal organization for individuals working in the various fields of medical care such as voluntary and public medical care plans, hospital services, group practice, chronic diseases, and rehabilitation to meet together for the presentation and discussion of their common problems." The letter is plausible, and is accompanied by a list of papers on the subject of medical care that have appeared in the *American Journal of Public Health*. The committee is composed of workers in the vineyard of Falk, Dailey, Sinai, Mountain, Reed. "'Nuf sed."

FOURTH ANNUAL CONFERENCE OF PRESIDENTS

SUNDAY, June 20, 1948, at the Sheraton Hotel in Chicago, the Fourth Annual Conference of Presidents and other Officers of State Medical Associations held an enthusiastic meeting. Three formal papers were presented, "Despotism by Consent of the Governed," Joseph H. Howard, M.D., of Bridgeport, Connecticut, President-elect; "The Blue Cross-Blue Shield Program," Paul R. Hawley, M.D., Blue Cross-Blue Shield Director, former Major General, former Chief Medical Director, Veterans Administration; "Why a State Medical Association," John W. Cline, M.D., San Francisco, Past President, California Medical Association.

The most challenging was General Hawley's warning about compulsory health insurance. We must not be complaisant. Plans and proceedings are under way to continue the socializing program. Money is not now available, but when the present war scare is over it could be diverted to other than national defense. And those now in strategic positions would not hesitate to further their continuing interests—the nationalizing of medicine, and all it means.

Upon suggestion of the Conference of Presidents, Dr. Hawley's speech was given at the House of Delegates of the American Medical Association, and at his request in executive session. The General says that final action on socializing of medicine will be decided by emotion, not by justice or reason.

THIRD GRASS ROOTS CONFERENCE

THE THIRD NATIONAL conference of County Medical Society Officers convened Sunday, June 20, 1948, at the Palmer House, Chicago, again conflicting with the Conference of Presidents. An impressive program was carried out on the general subject, "The County Medical Society." There were three divisions of the program: The County Medical Society—(1) Its Part in Medical Organization; (2) Its Responsibility to the Membership; (3) Its Responsibility to the Public. The discussions, in general, were very good, bringing out much of interest and value, and the discussions were unhampered. D. B. Wiley, M.D., of Utica, Michigan, led the discussion on "Medical Care-Serving the Public." The attendance was unusually good, the Red Lacquer Room being crowded.

COUNCIL ON MEDICAL SERVICE CONFERENCE

ON JUNE 19, 1948, at the AMA headquarters in Chicago, the Council on Medical Service held a conference of representatives from each state who had been invited to attend an informal meeting to study problems related to prepayment medical care and hospital care plans. Representatives of thirty-six states and Hawaii were present. This whole matter grew out of misunderstanding of what transpired at the Los Angeles conference of Blue Cross-Blue Shield Commissions. A repetition of free discussion similar to that at Los Angeles was widely enjoyed, and finally the entire matter was referred back to the Council for further

(Continued on Page 942)

In the People's Interest

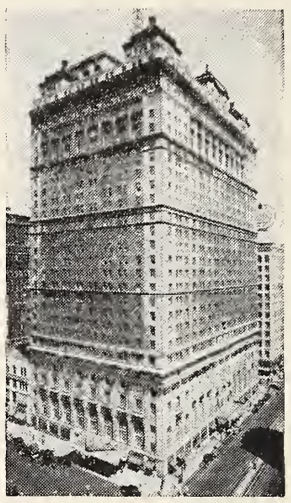
In a recent issue of *The Bulletin* of the Muskegon County Medical Society, Mr. Ralph Eggert of the *Muskegon Chronicle* indicated a few of the questions in the mind of Mr. John Q. Public in respect to the medical profession.

"Why are doctors so few? Why don't the medical colleges turn them out faster? Since most ailments are relatively simple—why do all doctors have to spend so many years in training? Why don't doctors give more pills—like they used to years ago, when they asked you to stick out your tonge and say 'ahhhhhh'? . . . Why do the doctors talk a queer lingo all of their own that the common folks can't understand? Why do the doctors stick together so closely—just like the lawyers, or teachers, or bricklayers, carpenters, truckers or what have you?"

If Mr. Public were to visit the Annual Session and Postgraduate Conference of the Michigan State Medical Society in September, 1948, his questions would be answered in full. For the Annual Session brings together each year the programs, policies, and people who have carried on the work of organized medicine in Michigan during the preceding twelve months. It does more, it offers a panoramic view of the science and practice of medicine itself.

Mr. Public Would Be Amazed

Mr. Public is a reasonable fellow when he knows the facts and his comment on what he had seen at the Conference might run something like this: "Whew! I didn't realize there were so many doctors. A coupla thousand were there—*working*, by George. They were taking notes all day long, exchanging knowledge derived from their own study and practice, looking at new devices, drugs, foods, techniques and literally wallowing in the science and practice of medicine. It's no wonder it takes so much study to be a good doctor of medicine when medicine has become so complicated by the very speed of its own developments and findings. "Queer lingo"? Yes, it sounds that way at first but the words are mostly names and, after all, names are names no matter how odd they sound. And I don't wonder that the doctors stick together—they're friends, so much so in fact that they give away to each other secrets that if they were to keep to themselves would make them a fortune and famous to boot. But do they "patent" their findings? No. As soon as they find something new they are positive of, they run to a conference



The Book-Cadillac Hotel
Headquarters for the 1948 MSMS Annual Session

like this and spill the works. That means the rest of the doctors—those who hear these teachers and researchers—learn how to do a better job and the public benefits. Come to think of it, I didn't hear a single word about how to make more money or any of the usual stuff of conventions—all I heard was how to make people more healthy and keep 'em that way. I'd say that this meeting, more than any other I've ever watched, was *in the people's interest.*"

There are over sixty such major medical meetings in the United States during the course of a single year. Yet Mr. Public, visiting the Michigan Session, would have had the opportunity to view one of the very best. In fact, while it is not the biggest of its kind, it is nationally recognized as an example of "how it should be done" because of its smooth timing and general completeness.

A Unique Annual Session

The question arises as to what has brought about this meeting which has become unique because of

its superiority. Strangely enough, the development of a medical meeting of this nature is dependent upon the behind-the-scenes, detailed work and thought of highly skilled persons—human engineers they are sometimes called. It is a matter of arrangements so that the businesses and pleasures of the conference flow smoothly, and those who attend receive the greatest good from their observa-



One of the General Assemblies at MSMS Annual Session



A Spot in the Famous MSMS Technical Exhibit

tion and participation. In Michigan, the answer very probably lies in the organizational genius of L. Fernald Foster, M.D., Secretary, and Mr. William J. Burns, Executive Secretary of the MSMS. The valuable guidance of President P. L. Ledwidge, M.D., Detroit, of Council Chairman O. O. Beck, M.D., Birmingham, plus the combined thinking of the hard-working Councilors, are apparent in the over-all policies that guide this superior show.

Yet, somebody has to make things "go" and at this the Foster-Burns team has proved itself past master.

Attendance—From 200 to 2,866!

Let's look at the record: At the first Annual Session in 1902 one speaker and slightly over 200 persons were present at Port Huron. At the last Session in Detroit (1946), there were 2,866 in attendance. Early Annual Sessions had no exhibits of surgical and pharmaceutical equipment to educate and interest the doctors. The 1947 Grand Rapids model has 120 technical and scientific exhibits displaying thousands of new devices and qualified drugs on the market today. It is unnecessary to continue comparisons, but it is interesting to note that the 1948 Session will be divided into seven General Assemblies, thirteen Section Meetings, twenty-two Discussion Conferences, and thirty-two major papers given by outstanding doctors from sixteen states and Canada. There will be numerous ancillary groups and associations meeting at the same time, fifty chairmen, as many secretaries, over 400 laymen working together, planned accommodations and entertainment for over 2,000 persons daily, and a "million" details. All this in addition to two full meetings of The Council and the annual two-day session of the House of Delegates transacting the business of organized medicine and establishing policy

Let us look behind the scenes to see some of the techniques which have been developed in Michigan to make the Annual Session more valuable and exciting. They may seem unimportant details, but it is these strokes of the organizational artist that "make" the meeting. Here are some examples:

Welcome

Ubiquitous Hosts.—When a speaker arrives in the city where the Session is to be held, he is greeted "at the station" by a friendly doctor of medicine who will be his host during the Session. This host is a resident of the city—who is especially interested in the specialty of the guest. The speaker is personally escorted to his hotel. Upon registering, the Desk Clerk hands him a personal letter of welcome from the President of the MSMS. He goes to his room and finds that a large bowl of fruit has preceded his arrival. If his lady accompanies him, flowers await her. Inquiries are made of the guest by his host as to what type of entertainment he prefers. If he wishes to play golf, an interesting match is arranged; if he wishes to see a new show, tickets are obtained; he is usually invited to the home of the host and is in general made to feel completely welcome.

This is most smoothly done for each of the distinguished visiting guest essayists. But before these pleasantries come to pass, many a letter and phone call goes into the mill. Who is to be the host? What time will the visitor arrive? Is he traveling by air, auto or train? Who accompanies him? What accommodations does he wish? et cetera. The answers to these questions must be obtained for each of the nearly eighty people involved. A special meeting is held of the Ubiquitous-Hosts-to-be; their duties and privileges are gone over in detail.

Yet, the whole thing is but one small detail of the Conference! The importance of the "detail" is reflected in the fact that Michigan repeatedly receives acceptances by the most renowned medical men to address MSMS. These speakers know that they will be welcome and have a pleasant time in Michigan. The benefit accrues to the membership of the Society, and through them to the people of Michigan.

Exhibits

The Maze.—An accepted valuable part of the Annual Session is the exhibit. In fact, the members cannot attend the meetings without going through the exhibit. And therein lies a story.

Exhibitors pay fees to exhibit their products. The money obtained from the exhibitors defrays the expense of the meeting just as the advertisements in a newspaper pay for its publishing. Most any good executive secretary can offer exhibit spaces to exhibitors and make arrangements for the location. The success of the exhibit, however, lies in making the exhibit worth while to both doctors and exhibitors. Evidence of the success of the MSMS exhibit is that all space is sold out

nine months before the meeting, and there is a long waiting list of exhibitors who would be happy to display their products if space were available.

The reason for this happy state of affairs in Michigan is because of the system devised by Executive Secretary Burns.



The Hospitality Booth—Manned by MSMS Officers



The MSMS Council in Action

When the doctor member arrives he traverses the exhibit in order to enter the assembly room.

Because of the Labyrinth-type arrangements of the booths, he must pass each one before he completes his journey. He is urged to stop and register, view the display and purchase if he so desires. Michigan doctors do so—and the "show" is a success!

Special intermissions are arranged throughout the day to view exhibits and when the assembly recesses the doctors again pass through the exhibits. The exhibitors have a high code of ethics and courtesy in offering their wares. "Working the Aisles" for example, which means obstructing the progress of the doctor through the exhibit to call his attention to a product, is strictly forbidden. A friendly attitude is maintained at all times by the high caliber representatives of firms which must qualify with top standard products before they are invited to exhibit in Michigan.

As a result, the doctors are happy to spend time at the booths. In turn, the exhibitors are enthusiastic over their extraordinarily friendly reception in Michigan. Who benefits? Its mutual, of course, but in the end the Public is the big winner because the flow of life-guarding techniques, appliances and medicines is hastened and the quality is superior.

House of Delegates

The meeting of the House of Delegates, the supreme governing body of the MSMS, is of top importance at every Annual Session. This is almost an organization within an organization for it has its own officers, committees, registration and press rooms and its members consider problems and develop pioneering projects which have made the Michigan State Medical Society known the world around.

It is from the House of Delegates as the fountain head that Michigan Medical Service came into being, a service which Senator Arthur H. Vandenberg has called "Michigan's Greatest Public Trust." It is from the House of Delegates that the disease control projects, the postgraduate training programs, the high standards of medicine, and the "Medical Associates" have emanated. And tracing back in each instance it was "in the public interest" that each action was taken. The story of the House is a theme in itself, so we'll leave it till another issue.

You

In the meantime, with the proud assurance that 1948 will see the finest Annual Session and Postgraduate Conference of the progressive Michigan State Medical Society, the invitation to attend is cordially repeated with the knowledge that only by the participation of members can this meeting be truly of greatest value and give maximum service—in the people's interest.

Second Annual

MICHIGAN RURAL HEALTH CONFERENCE

Thursday-Friday, September 16-17, 1948

on the campus of Michigan State College, East Lansing

under sponsorship of

MICHIGAN STATE MEDICAL SOCIETY

and 39 other associations and agencies

You Are Invited to Attend

For Program, Write H. B. Zemmer, M.D., 2020 Olds Tower, Lansing 8, Michigan

THE 83rd ANNUAL SESSION
MICHIGAN STATE MEDICAL SOCIETY
Detroit

ANNUAL SESSION INFORMATION

DIRECTORY

Headquarters—Book-Cadillac Hotel, Detroit

Registration—Fifth Floor, Book-Cadillac Hotel

MSMS Hospitality Booth—Fifth Floor, Book-Cadillac Hotel

General Assemblies—Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

Technical Exhibit—Fourth Floor, Book-Cadillac Hotel

Press Room—Parlor H, Fifth Floor, Book-Cadillac Hotel

Woman's Auxiliary Headquarters—Fort Shelby Hotel, Detroit

* * *

♦ **Register—Fifth Floor, Book-Cadillac Hotel, Detroit —as soon as you arrive.**

Hours:	Tuesday, September 21	1:00 to 5:00 p.m.
	Wednesday, September 22	8:30 to 5:30 p.m.
	Thursday, September 23	8:30 to 5:30 p.m.
	Friday, September 24	8:30 to 3:30 p.m.

NO REGISTRATION FEE FOR AMA AND CANADIAN MA MEMBERS.

Admission will be by badge only to all Scientific Assemblies, and Section Meetings.

Bring your MSMS or AMA Membership Card to expedite registration.

* * *

♦ **Guests**—Members of the American Medical Association from any state, or from a province of Canada and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. No registration fee. Please present credentials at the Registration Desk.

Bona fide doctors of medicine serving as interns, residents, or who are associate or probationary members of county medical societies, if vouched for by an MSMS Councilor or the president or secretary of a county medical society, will be registered as guests. Please present credentials at the Registration Desk.

* * *

♦ **Michigan Doctors of Medicine**, not members, if listed in the American Medical Directory, may register as guests upon payment of $5.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1948 ONLY, provided they subsequently are accepted as members by their County Medical Society.

* * *

♦ **Telephone Service**—Local and Long Distance telephone service will be available in the Book-Cadillac Hotel.

In case of emergency, doctors will be paged from the meetings by announcement on the screen.

Call the Book-Cadillac Hotel, Cadillac 8000 and ask for the MSMS telephone extensions.

♦ **Checkroom** is available in the Book-Cadillac Hotel, Fourth Floor near Grand Ballroom.

* * *

♦ **Guest Essayists** are very respectfully requested not to change time of their lecture with another speaker without the approval of the General Assembly. This request is made in order to avoid confusion and disappointment on the part of some members of the audience.

* * *

♦ **Douglas Donald, M.D., Detroit,** is General Chairman of the Detroit Committee on Arrangements for the 1948 MSMS Annual Session.

* * *

♦ **Transportation**—The Pere Marquette Streamliners afford a convenient means of transportation to the MSMS Annual Session in Detroit for hundreds of physicians in the central and southeastern part of the State. Order reservations well in advance.

* * *

♦ **Doctor, register Tuesday!** Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m. —as well as on Wednesday, Thursday, Friday, during the 1948 MSMS Annual Session. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening General Assembly.

We recommend to Detroit physicians, and those who arrive in Detroit, Tuesday, that they register Tuesday, September 21, from 1:00 to 5:00 p.m.—Fifth Floor, Book-Cadillac Hotel, Detroit.

* * *

♦ **Press Relations Committee**—H. F. Dibble, M.D., Detroit, Chairman: W. A. Chipman, M.D., Detroit; L. T. Henderson, M.D., Detroit; R. A. Johnson, M.D., Detroit; J. J. Lightbody, M.D., Detroit; and C. J. Smyth, M.D., Detroit.

PAPERS WILL BEGIN AND END ON TIME

Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time, in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

You Are Cordially Invited
To Visit the
MICHIGAN STATE MEDICAL SOCIETY
HOSPITALITY BOOTH
Fifth Floor, Book-Cadillac Hotel
Stop and Chat with Your State Officers

♦ **"Ubiquitous Hosts"**—the following Detroit doctors of medicine have placed themselves at the disposal of the twenty-eight visiting guest essayists who are on the program of the 83rd Annual Session in Detroit; they will demonstrate the meaning of Michigan hospitality to the eminent speakers from other parts of the United States and Canada: C. D. Benson, M.D., R. W. Cavell, M.D., G. E. Chittenden, M.D., E. L. Cooper, M.D., J. E. Croushore, M.D., L. S. Eno, M.D., E. H. Fenton, M.D., F. W. Hartman, M.D., J. B. Hartzell, M.D., R. A. Johnson, M.D., C. G. Johnston, M.D., H. L. Keim, M.D., R. W. McClure, M.D., G. T. McKean, M.D., T. H. Miller, M.D., R. C. Moehlig, M.D., J. G. Molner, M.D., J. C. Montgomery, M.D., E. A. Osius, M.D., G. C. Penberthy, M.D., J. P. Pratt, M.D., H. B. Rothbart, M.D., H. C. Saltzstein, M.D., R. J. Schneck, M.D., I. B. Taylor, M.D., W. H. Ulrich, M.D., all of Detroit, and G. A. Zindler, M.D., of Battle Creek and A. B. Stearns, M.D., of Grosse Pte. Woods.

Sincere thanks are extended these hosts for their tangible help in making the MSMS Annual Session of 1948 an outstanding success.

* * *

♦ **Public Meeting**—The evening assembly of Wednesday, September 22, 1948—Officers Night—will be open to the public. Invite your patients and other friends to this interesting meeting. The program (complete on page 901) is highlighted by:

8:30 p.m. President's Address
Induction of President-Elect
10:00 p.m. Biddle Oration

* * *

♦ **Members of Michigan Medical Service** will meet in annual session Monday, September 20, 2:00 p.m., in the Grand Ballroom, Book-Cadillac Hotel, Detroit.

TWENTY-TWO DISCUSSION CONFERENCES

These quiz periods will be held Wednesday, Thursday, and Friday, September 22, 23, 24, at 5:00 to 6:00 p.m. An opportunity to ask questions concerning the presentation of the guest essayist, or to discuss one of your interesting cases with them, will be provided.

WEDNESDAY: Discussion Conferences on Anesthesia, Dermatology, General Practice, Medicine, Obstetrics, Pediatrics, Surgery and Urology.

THURSDAY: Discussion Conferences on Gynecology-Obstetrics, Medicine, Ophthalmology, Otolaryngology, Pediatrics, Public Health and Preventive Medicine, and Surgery.

FRIDAY: Discussion Conferences on General Practice, Medicine, Nervous and Mental Diseases, Pathology, Pediatrics, Surgery and Syphilology.

Please submit your questions, on forms printed in the Program* to the Secretary of the General Assembly immediately after the termination of the lecture, in order that the guest essayist may have time to consider same before the quiz period at 5:00 p.m.

*Forms in official program.

♦ **Register at Every Booth**—there is something of interest or education in the large exhibit of technical displays. Stop and show your appreciation of the exhibitors' support in helping to make successful the 1948 MSMS Convention.

* * *

♦ **State Society Night**—Thursday, September 23, 1948. 10:00 p.m. Dancing for MSMS, AMA and CMA members and their ladies. Grand Ballroom, Book-Cadillac Hotel, Detroit.

* * *

♦ **The Annual Committee Organization** luncheon, a meeting of MSMS committee chairmen appointed by President-elect E. F. Sladek, M.D., Traverse City, to serve during the year 1948-49, will be held on Wednesday, September 22, 12:00 noon in Suite 808 of the Book-Cadillac Hotel.

* * *

♦ **Technical Exhibits**—83 exhibits—will open daily at 8:30 a.m. and close at 5:30 p.m. Frequent intermissions to view the exhibits have been arranged before, during and after the General Assemblies and Section Meetings. The public is barred from the exhibits.

PLEASE REGISTER AT EACH BOOTH.

* * *

♦ **Seven General Assemblies**, Wednesday, Thursday, Friday, September 22, 23, 24 (see pages 899-907).

Thirteen Section Meetings on Wednesday, Thursday, Friday, September 22, 23, 24. All Sections will meet at luncheons in the Book-Cadillac Hotel. 12:00 noon to 1:30 p.m. (see pages 899-900; 903-904; 906).

* * *

♦ **House of Delegates, MSMS**, convenes Monday, September 20 at 10:00 a.m., Book-Cadillac Hotel, Detroit; it will hold two meetings on Monday, September 20, at 10:00 a.m. and at 8:00 p.m.; also two meetings on Tuesday, September 21, at 10:00 a.m. and at 8:00 p.m.

THE WOMAN'S AUXILIARY TO THE MICHIGAN STATE MEDICAL SOCIETY

Will present an attractive social and business program at the Fort Shelby Hotel, Detroit, to which the wife of every MSMS, AMA and CMA member is cordially invited.

♦ **Meetings of Special Societies, Alumni and Auxiliary Groups.**

1. **American Academy of General Practice of Wayne County**, quarterly meeting, and organizational meeting of **Michigan Academy of General Practice**, Wayne Room, Statler Hotel, Detroit, Thursday, September 23, 7:30 to 10:00 p.m. Adjournment in time for MSMS dancing party at the Book-Cadillac Hotel.
2. **Detroit Urological Society**, Tuesday, September 21, Pan American Room, Book-Cadillac Hotel, Detroit, 6:30 p.m. dinner. John Dees, M.D., Durham, North Carolina, honor guest, will speak on "Epispadias."

3. **Wayne University Alumni Association** will meet Thursday, September 23, Suite 808, Book-Cadillac Hotel, Detroit, 7:00 p.m. dinner.
4. **Medical Assistants' Conference,** Thursday, September 23, 7:00 p.m., English Room, Book-Cadillac Hotel, Detroit.
   Secretaries and technicians of all MSMS members are cordially invited to attend this informative conference. No registration fee.
5. **The Michigan Society of Anesthesiology** will meet Wednesday, September 22, Parlor H, Book-Cadillac Hotel, Detroit, 7:30 p.m. (dinner). I. B. Taylor, M.D., President, Detroit, is in charge of arrangements.
6. **The Detroit Pediatric Society and Michigan Branch, American Academy of Pediatrics,** will hold a joint meeting at the Whittier Hotel, Detroit, Thursday, September 23. Dinner at 6:30 p.m. Tickets may be procured at MSMS Registration Desk.
7. **Loyola University Medical School** graduates will be the guests of the Detroit Club of the Alumni Association for dinner at the Book-Cadillac, Thursday, September 23. Cocktails at 6:30. Dinner tickets can be purchased at the door. Wives of alumni are welcome at the dinner.
8. **Woman's Auxiliary Social Hour and Dinner.** A social hour, arranged through the courtesy of Parke, Davis & Co., will precede the Woman's Auxiliary dinner for doctors and their wives, scheduled for the Fort Shelby Hotel, Detroit on Wednesday, September 22.

   The social hour will begin at 5:45 p.m. Entertainment will include The Four Dukes, zany Detroit entertainers whose antics are making them nationally famous.

   The Woman's Auxiliary dinner will begin at 6:30 p.m. and end at 8:15 p.m., in time for the attendance of doctors and their wives at the Officers Night ceremonies in the Book-Cadillac Hotel, 8:30 p.m.

   All MSMS members are very cordially invited by the Woman's Auxiliary to attend its cocktaill hour and dinner of September 22.

♦ **Postgraduate Credits** are given to every MSMS member who attends the 83rd Annual Scientific Session of the Michigan State Medical Society, Wednesday, Thursday, and Friday, September 22, 23, 24, 1948 in Detroit.

Woman's Auxiliary



Mrs. T. Grover Amos
President, MSMS Auxiliary

COMMITTEE ON CONVENTION ARRANGEMENTS

Mrs. L. Paul Sonda .....Convention Chairman
Mrs. Frederick G. Buesser, Mrs. William L. Foster
Convention Co-chairmen
Credentials and Registration—Mrs. William L. Foster
Social—Mrs. Norman O. LaMarche
Hospitality—Mrs. Frederick G. Buesser
Publicity—Mrs. Clarence L. Candler
Finance—Mrs. Robert L. Novy
Program—Mrs. William L. Sherman
Flowers—Mrs. Audrey O. Brown
Pages—Mrs. Milton A. Darling
Courtesy—Mrs. Howard P. Doub
Printing—Mrs. Herman D. Scarney

CONVENTION HEADQUARTERS

Fort Shelby Hotel

Registration Hours

Tuesday, September 21 .....9 a.m.- 4 p.m.
Wednesday, September 22 .....9 a.m.- 4 p.m.
Thursday, September 23 .....9 a.m.-12 m.

Program

Tuesday, September 21

6:00 p.m. **Subscription Dinner**
Sky Room

8:00 p.m. **Bridge**

Wednesday, September 22

11:00 a.m. **Pre-Convention Board Meeting**
River Room

12:30 p.m. **Luncheon**
Sky Room

5:00 p.m. **Get-Acquainted Hour**
Honoring the National President, Mrs. Luther K. Kice—State Presidents—Music by "The Dukes"

6:00 p.m. **Banquet**
Spanish Room
Speakers—Haven Emerson, M.D., New York; Warren W. Furey, M.D., Chicago

Thursday, September 23

10:00 a.m. **Annual Meeting**
Spanish Room

12:30 a.m. **Annual Luncheon**
Crystal Room
Speaker: E. F. Sladek, M.D., Traverse City, President-Elect, MSMS. Subject: "Working Together."
"Ye Aulde Album Style Show" by members of Wayne County Auxiliary

GUEST SPEAKERS



Daniel Blain, M.D.



A. Brunschwig, M.D.



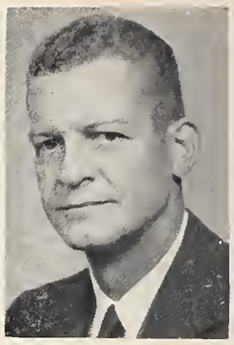
C. C. Burlingame, M.D.



S. C. Cullen, M.D.



M. E. Davis, M.D.



J. E. Dees, M.D.



L. R. Dragstedt, M.D.



Haven Emerson, M.D.



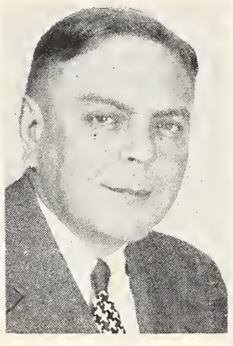
T. C. Galloway, M.D.



Arnold Gesell, M.D.



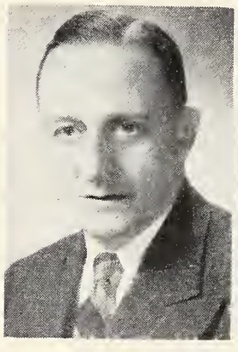
R. L. J. Kennedy, M.D.



H. J. Kullman, M.D.



F. H. Lahey, M.D.



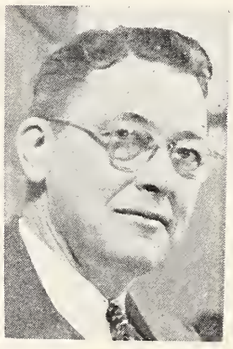
M. D. Leigh, M.D.



R. R. Linton, M.D.



W. L. Palmer, M.D.



D. M. Pillsbury, M.D.



G. H. Pratt, M.D.



T. G. Randolph, M.D.



W. J. Reich, M.D.



S. P. Reimann, M.D.



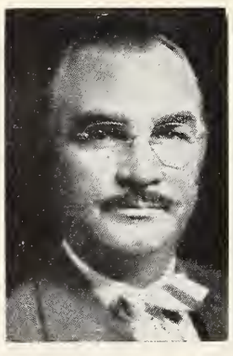
R. W. TeLinde, M.D.



Philip Thorek, M.D.



Waltman Walters, M.D.



E. G Waters, M.D.



A. R. Woodburne, M.D.



I. S. Wright, M.D.

Eighty-Third Annual Session and Postgraduate Conference--1948

PROGRAM OF GENERAL ASSEMBLIES AND SECTIONS

WEDNESDAY MORNING
September 22, 1948

First General Assembly

Grand Ballroom, Book-Cadillac Hotel

Chairman: W. H. Huron, M.D., Iron Mountain
Secretary: G. T. McKean, M.D., Detroit

A.M.

9:00 "Present Status of Treatment of Thyroid Disease"
F. H. Lahey, M.D., Boston

Director of the Lahey Clinic; Surgeon-in-chief to the New England Baptist Hospital and the New England Deaconess Hospital.

This paper will discuss particularly our experience in dealing with the preparation of patients with hyperthyroidism for surgery with the anti-thyroid agents, thiouracil, propylthiouracil and methylthiouracil. We will discuss in it our experiences with the three different drugs, the percentage of complications with each, the treatment particularly of agranulocytosis, the time as indicated by white and differential counts when the drug should be omitted and the plans we have developed for changing from one drug to another when complications have arisen.

It will discuss the plans which we have developed in this experience to combine iodine with the propylthiouracil, the advantages and disadvantages of giving it from the beginning combined with the thiouracil and the present plan which is now employed of giving it only in the last three weeks. It will discuss some of the mistakes which are made with propylthiouracil in the way of bringing the metabolism inadequately to normal. It will discuss the administration of the drug in some of the complications which occur in hyperthyroidism such as hyperthyroidism in children, hyperthyroidism in pregnancy, in diabetes, in cardiac disease, in patients with psychoses and with thrombocytopenic purpura.

Some of the other problems of thyroid disease will be discussed such as a method of differentiating falsely elevated metabolisms from truly elevated metabolisms in patients without the clinical evidence of hyperthyroidism. Some of the technical problems of thyroidectomy, some of the complications following thyroidectomy will be discussed as will the methods of anesthesia employed in the surgical treatment of this disease.

9:30 "The Modern Treatment for Myocardial Infarctions including the Use of Anticoagulants"
I. S. Wright, M.D., New York City

Associate Professor of Clinical Medicine, Cornell University Medical College; Chief of the Vascular Section of the Department of Medicine, Cornell University Medical College and New York Hospital; Civilian Consultant in Medicine to the Surgeon General—U. S. Army.

The conventional treatment for myocardial infarctions will be briefly discussed. The importance of oxygen therapy and of the use of plasma for combating shock will be presented. The results from the use of anticoagulants in the treatment of coronary thrombosis with myocardial infarctions will be evaluated. This form of therapy constitutes the most important contribution to the care of the patient with myocardial infarction since the development of the electrocardiogram. The death rates can be reduced one-third per attack, and the complication rate can be reduced more than one-half per attack. Analyses of the study of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infactions will be reviewed.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 "The Rational Application of Sedative Drugs"
S. C. Cullen, M.D., Iowa City, Iowa

Associate Professor of Surgery, Chairman, Division of Anesthesiology, The State University of Iowa.

The non-volatile sedative drugs commonly used prior to anesthesia are too often given on a routine and empirical basis. Each of these drugs has specific pharmacologic properties which can be used with benefit to the patient, the surgeon and the anesthesiologist if they are administered with reference to particular functions.

Delineation of the useful properties of morphine, atropine, scopolamine and the short acting barbiturates will be made with special reference to the application of these drugs in preanesthetic medication, but also with a discussion of proper utilization in other areas of medical practice. A brief outline of the properties of new substitutes for morphine will be presented.

11:30 "Radiation Effects on the Skin and Their Treatment"
A. R. Woodburne, M.D., Denver, Colorado
Dermatologist.

This paper is a discussion of the various types of reaction which are produced by radiation of short wave length; those produced by the Grenz Ray, X-Ray and Radium.

Damage produced by various quality of radiation is discussed.

The usual causes of radiation damage as seen in patients and scientists, notably physicians, dentists and veterinarians, are discussed.

The ineffectiveness of usual methods of treatment is reviewed and a rational approach to therapy based on histopathologic findings is outlined.

Photographic and microphotographic demonstration.

12:00 End of First General Assembly

INTERMISSION TO VIEW EXHIBITS

Program of Sections

WEDNESDAY NOON
September 22, 1948

12:00 to 1:30 p.m. (luncheon)

SECTION ON DERMATOLOGY

Founders Room, Book-Cadillac Hotel

Chairman: J. H. Cobane, M.D., Detroit
Secretary: H. H. Holman, M.D., Detroit

"Nodular Diseases of the Extremities"
A. R. Woodburne, M.D., Denver, Colorado

In this discussion a reorientation of nodular diseases of the extremities will be attempted.

In recent years much work has been done and new approaches developed to the various types of erythema nodosum; a much wider knowledge of polyarteritis nodosa and its various etiologic agents has developed, particularly the allergic responses to toxins and drugs.

Erythema induratum as a purely tuberculous entity has been seriously questioned, and other nodular vascular manifestations have been separated from this group.

The whole problem is discussed from the standpoint of etiology rather than morphology.

SECTION ON ANESTHESIA

Suite 500, Book-Cadillac Hotel

Chairman: H. J. VanBelois, M.D., Grand Rapids

"Nitrous Oxide—Curare Anesthesia for Major Surgery"

S. C. Cullen, M.D., Iowa City, Iowa

In the past and in many areas in the present, nitrous oxide is considered useful only in those situations in which short anesthesia is needed and no muscular relaxation is required. The non-toxic property of nitrous oxide in the presence of sufficient oxygen has been long established and with the advent of curare in anesthetic practice, it is now possible to use nitrous oxide in non-asphyxial concentrations for surgical procedures that are long and require excellent muscular relaxation. This combination has been used successfully for gastric resections, abdomino-perineal resections, pulmonary resections and resections of the colon. It appears to provide a fire-proof and safe anesthesia with few complications.

* * *

SECTION ON UROLOGY

Parlors G-H-I, Book-Cadillac Hotel

Chairman: W. L. Sherman, M.D., Detroit
Secretary: C. F. Schroeder, M.D., Detroit

"Unexplained Renal Hematuria"

J. E. Dees, M.D., Durham, North Carolina

Serious disease of the urinary tract is often ushered in, or associated with, gross heamturia. These disorders include benign and malignant tumors, tuberculosis, non-specific infection, stone, nephritis, and the obstructive uropathies. In spite of prompt and exhaustive investigation, an occasional instance of gross, unilateral renal hematuria is encountered which, because of lack of additional abnormal findings, must be classified as unexplained, or "essential" hematuria. Probably no urologist is comfortably satisfied with this "exclusion" type of diagnosis. The present review of Duke Hospital patients whose renal hematuria was initially unexplained has been made with the hope of ascertaining their ultimate findings and diagnosis.

* * *

SECTION ON GYNECOLOGY AND OBSTETRICS

Pan American Room, Book-Cadillac Hotel

Chairman: P. W. Willits, M.D., Grand Rapids
Secretary: M. M. Rozan, M.D., Lansing

"Abdominal versus Vaginal Delivery"

M. E. Davis, M.D., Chicago

Cesarean section has become a very safe procedure in most large institutions. Nevertheless, the operation carries considerable mortality in the country at large. Furthermore, most patients who have had one abdominal delivery are committed to at least one or more such procedures during their reproductive careers. Thus, cesarean section mortality should include the combined mortality of the several deliveries.

Too many abdominal deliveries are performed in the United States. However, too few are done at the proper time. A careful study of the indications and the contraindications of the operation will result in a proper perspective for this important procedure. Indications for elective cesarean section have become well standardized and the carefully conducted "tests of labor" intelligently interpreted will decide the course in many patients with relative indications. Statistics from the Chicago Lying-in Hospital will be presented.

WEDNESDAY AFTERNOON
September 22, 1948

Second General Assembly

Grand Ballroom, Book-Cadillac Hotel

Chairman: E. A. Oakes, M.D., Manistee
Secretary: W. S. Jones, Menominee

P.M.

1:30 **"The Periodic Diagnosis of Infant Development. Its Significance in a Preventive Program of Clinical Supervision both for Normal and Handicapped Children."**

A. L. Gesell, M.D., New Haven, Connecticut
Director of the Clinic of Child Development, Yale University; Professor of Child Hygiene, Yale School of Medicine; Attending Physician at New Haven Hospital.

Development as well as disease falls within the scope of clinical medicine. It also falls within the purview of general practice.

Behavior is the most significant and inclusive index of developmental status. The developmental examination of infant behavior accomplishes five results:

1. It ascertains stages and degrees of maturity.
2. It leads to early differential diagnosis of normality, defect, and deviation.
3. It reveals neurologic defects and sensory handicaps not disclosed by ordinary methods of clinical examination.
4. It supplies important objective information concerning the organization of personality.
5. Periodic examinations make possible a constructive type of developmental supervision which takes mental health into account.

2:00 **"Epispadias with Incontinence"**

J. E. Dees, M.D., Durham, North Carolina
Assistant Professor of Urology, Duke University Medical School.

2:30 **"The Management of the Placental Stage in the Prevention of Postpartum Hemorrhage"**

M. E. Davis, M.D., Chicago
Joseph Bolivar DeLee, Professor of Obstetrics and Gynecology at the University of Chicago and the Chicago Lying-in Hospital.

Postpartum hemorrhage is an important cause of maternal morbidity and mortality. Excessive blood loss often has its origin in the placental stage of labor. The most common causes of postpartum hemorrhage are failure of normal and complete separation of the placenta; uterine atony due to a variety of causes such as long labor, a poor labor mechanism, excessive use of analgesia and anesthesia, the retention of placental fragments; trauma; the complications of pregnancy and labor such as placenta previa and abruptio placentae.

Labor is conducted artificially today in hospital practice so the placental stage can no longer remain natural. The use of ergonovine at the end of the second stage and the prompt expression of the placenta will decrease complications and the hazard of excessive blood loss. The careful preparation of the patient for labor, adequate facilities for safe and prompt blood transfusion, good obstetrics, the intelligent conduct of the third stage and the dynamic treatment of excessive blood loss should almost eliminate deaths from hemorrhage.

3.00 **INTERMISSION TO VIEW EXHIBITS**

4:00 "Acute Abdominal Emergencies"

PHILIP THOREK, M.D., Chicago

Assistant Clinical Professor of Surgery, University of Illinois College of Medicine; Associate Professor, Cook County Graduate School of Medicine; Associate Attending Surgeon, Cook County Hospital; Attending Surgeon, Alexian Brothers' Hospital and American Hospital; Diplomate of the American Board of Surgery; Fellow of the American College of Surgeons.

Acute abdominal emergencies still continue to present one of the most vexing problems diagnostically and therapeutically which the practitioner as well as the surgeon is confronted with. Having gone through the charts of the Cook County Hospital for a period of eight years, six outstanding conditions account for ninety per cent of the diagnostic errors. These are: (1) acute appendicitis, (2) acute cholecystitis, (3) perforated peptic ulcer, (4) acute hemorrhagic pancreatitis, (5) renal colics and (6) acute coronary occlusion. A simple plan for diagnosing is presented and this is utilized in each of the above-mentioned conditions. Some of the more modern tests are stressed, and the importance and value of the "scout" x-ray film is discussed.

4:30 "Present Status of the Treatment of Peptic Ulcer"

WALTMAN WALTERS, M.D., Rochester, Minnesota

Professor of Surgery, Mayo Foundation; Head of Section in Surgery, Mayo Clinic.

The operation of resection of the vagus nerves in the treatment of peptic ulcer is not a new procedure but Dragstedt deserves credit for reviving interest in it and calling attention to its value, particularly in cases of recurring ulceration after resection of the stomach. In such cases it has a very definite indication. The immediate relief of pain and the lack of any undesirable symptoms are striking. Resection of the vagus nerves also has a place in the treatment of recurring ulcer after gastro-enterostomy.

Ulcers may recur not only after gastro-enterostomy or gastric resectioin but also after vagotomy. Also, in some cases ulcerating lesions have failed to heal after vagotomy.

The most troublesome thing following the operation of vagotomy is the dilatation of the stomach; disturbances of motility, produced in more than 14 per cent of my cases, have persisted for many months.

Partial gastrectomy remains the operation of choice in the treatment of chronic recurring gastric ulcer and in most cases of surgical duodenal ulcer.

5:00 End of Second General Assembly

5:00 DISCUSSION CONFERENCES IN ANESTHESIA, DERMATOLOGY, GENERAL PRACTICE, MEDICINE, OBSTETRICS, PEDIATRICS, SURGERY AND UROLOGY.

(See Page 902)

WEDNESDAY EVENING

September 22, 1948

Third General Assembly

Grand Ballroom, Book-Cadillac Hotel

President: P. L. LEDWIDGE, M.D., Detroit,

Secretary: L. FERNALD FOSTER, M.D., Bay City,

P.M.

8:30 Officers' Night—Public Meeting

1. Call to order, and announcements and reports of the House of Delegates, by L. Fernald Foster, M.D.
2. Introduction of President P. L. Ledwidge, M.D., followed by President's Annual Address.
3. Introduction of President-Elect E. F. Sladek, M.D., Traverse City, and induction into office as President of the Michigan State Medical Society by the Retiring President. Response of Dr. Sladek.
4. Introduction of the new President-Elect and other recently elected Officers and of the Chairman of the Council, O. O. Beck, M.D., Birmingham.
5. Presentation of scroll and Past President's Key to Dr. Ledwidge by the Chairman of the Council, Dr. Beck.
6. Induction of members into the MSMS "Fifty-Year Club" by Retiring President Dr. Ledwidge.

9:15 7. The Andrew P. Biddle Oration.

8. Presentation of Biddle Oration scroll.



ANDREW P. BIDDLE, M.D.
Patron of Postgraduate Medical Education
(Deceased August 2, 1944)

10:00 End of Third General Assembly.

Twenty-Two Discussion Conferences (Quiz Periods)

All Meetings in the Book-Cadillac Hotel, Detroit

Twenty-two Discussion Conferences each with a different chairman—a leader of outstanding ability in his field—will be held Wednesday, Thursday, Friday afternoons, immediately following the end of the General Assembly program for the day. Here is your chance to ask questions of the lecturers and to hear discussed medical matters of value to you in your daily practice.

WEDNESDAY, SEPTEMBER 22, 1948
5:00 to 6:00 p.m.

ANESTHESIA
Parlor J
Leader
N. M. Bittrich, M.D.
Detroit
Guest Conferee
S. C. Cullen, M.D.
Iowa City, Iowa

OBSTETRICS
Founders Room
Leader
N. F. Miller, M.D.
Ann Arbor
Guest Conferee
M. E. Davis, M.D.
Chicago

DERMATOLOGY
Suite 808
Leader
George VanRhee, M.D.
Detroit
Guest Conferee
A. R. Woodburne, M.D.
Denver, Colorado

PEDIATRICS
Parlors G-H-I
Leader
Frank Van Schoick, M.D.
Jackson
Guest Conferee
A. L. Gesell, M.D.
New Haven, Conn.

GENERAL PRACTICE
Pan American Room
Leader
E. C. Texter, M.D.
Detroit
Guest Conferee
Philip Thorek, M.D.
Chicago

SURGERY
Grand Ballroom
Leader
F. A. Coller, M.D.
Ann Arbor
Guest Conferees
Waltman Walters, M.D.
Rochester, Minn.
F. H. Lahey, M.D.
Boston

MEDICINE
English Room
Leader
R. J. Schneck, M.D.
Detroit
Guest Conferee
I. S. Wright, M.D.
New York City

UROLOGY
Suite 500
Leader
R. M. Nesbit, M.D.
Ann Arbor
Guest Conferee
J. E. Dees, M.D.
Durham, N. C.

THURSDAY, SEPTEMBER 23, 1948
5:00 to 6:00 p.m.

GYNECOLOGY-OBSTETRICS
Founders Room
Leader
W. F. Seeley, M.D.
Detroit
Guest Conferees
R. W. TeLinde, M.D.
Baltimore
E. G. Waters, M.D.
Jersey City, N. J.

OTOLARYNGOLOGY
Pan American Room
Leader
Wadsworth Warren, M.D.
Detroit
Guest Conferee
T. C. Galloway, M.D.
Evanston, Ill.

MEDICINE
English Room
Leader
J. W. Towey, M.D.
Powers
Guest Conferee
J. B. Barnwell, M.D.
Washington, D. C.

PEDIATRICS
Parlors G-H-I
Leader
J. L. Law, M.D.
Ann Arbor
Guest Conferee
R. L. J. Kennedy, M.D.
Rochester, Minnesota

OPHTHALMOLOGY
Suite 500
Leader
A. D. Ruedemann, M.D.
Detroit
Guest Conferee
F. H. Adler, M.D.
Philadelphia

PUBLIC HEALTH AND PREVENTIVE MEDICINE
Suite 808
Leader
B. H. Douglas, M.D.
Detroit
Guest Conferee
Haven Emerson, M.D.
New York City

SURGERY
Grand Ballroom
Leader
C. D. Brooks, M.D.
Detroit
Guest Conferees
L. R. Dragstedt, M.D.
Chicago
R. R. Linton, M.D.
Brookline, Mass.

FRIDAY, SEPTEMBER 24, 1948
5:00 to 6:00 p.m.

GENERAL PRACTICE
Pan American Room
Leader
H. B. Zemmer, M.D.
Lapeer
Guest Conferee
W. J. Reich, M.D.
Chicago

PATHOLOGY
Founders Room
Leader
C. I. Owen, M.D.
Detroit
Guest Conferee
S. P. Reimann, M.D.
Philadelphia

MEDICINE
English Room
Leader
Douglas Donald, M.D.
Detroit
Guest Conferees
W. L. Palmer, M.D.
Chicago
H. J. Kullman, M.D.
Dearborn

PEDIATRICS
Parlors G-H-I
Leader
R. M. Kempton, M.D.
Saginaw
Guest Conferee
M. D. Leigh, M.D.
Vancouver, B. C., Canada

NERVOUS AND MENTAL DISEASES
Suite 500
Leader
R. M. Patterson, M.D.
Ann Arbor
Guest Conferees
Daniel Blain, M.D.
New York City
C. C. Burlingame, M.D.
Hartford, Conn.

SURGERY
Grand Ballroom
Leader
R. L. Mustard, M.D.
Battle Creek
Guest Conferees
Alexander Brunschwig, M.D.
New York City
G. H. Pratt, M.D.
New York City

SYPHILOLOGY
Suite 808
Leader
A. E. Schiller, M.D.
Detroit
Guest Conferee
D. M. Pillsbury, M.D.
Philadelphia

ALL MEMBERS ARE INVITED TO JOIN IN THESE QUIZ PERIODS WITH THE GUEST ESSAYISTS

THURSDAY MORNING
September 23, 1948

Fourth General Assembly

Grand Ballroom, Book-Cadillac Hotel

Chairman: O. O. Beck, M.D., Birmingham
Secretary: E. M. Pettis, M.D., Muskegon

A.M.

9:00 **"Present-Day Indications for Hysterectomy"**

R. W. TeLinde, M.D., Baltimore

Gynecologist-in-Chief, The Johns Hopkins Hospital, and Professor of Gynecology, The Johns Hopkins University.

Hysterectomy is discussed from the standpoint of its indications for various pathological lesions. Its abuse is also discussed with special reference to its use for asymptomatic fibroids and for minor lesions which could be cured by a lesser procedure. The indications for and dangers of total hysterectomy are considered. Attention is called to the fact that its routine use has resulted in an increase in the incidence of vesico-vaginal fistulas. Vaginal hysterectomy is also discussed in its relation to uterine prolapse. Finally, the place of hysterectomy in the treatment of carcinoma of the corpus and cervix uteri is considered.

9:30 **"Secretional Respiratory Obstruction and Bulbar Poliomyelitis"**

T. C. Galloway, M.D., Evanston, Illinois

Associate Professor of Otolaryngology, Northwestern University Medical School; Attending Otolaryngologist, Evanston Hospital; Attending Otolaryngologist, Cook County Hospital.

The conception of bulbar poliomyelitis as largely a problem in respiratory obstruction by secretion has greatly changed the outlook in this disease. Treatment based on that idea has been effective. During 1947 at the Evanston Hospital there were no deaths in sixty-two cases of acute poliomyelitis of which seven were of the bulbar type. Five of these required tracheotomy.

Central depression was usually relieved by clearing the airway with use of the respirator, so was probably due to anoxia and not infection. Indications for tracheotomy are detailed. Oxygen, parenteral fluids, postural drainage with the respirator and tracheotomy under certain given indications should save most patients with this disease. Tetanus after curare responds to the same treatment.

10:00 INTERMISSION TO VIEW EXHIBITS

11:00 **"Significance of Blood in the Stools in Infants and Children"**

R. L. J. Kennedy, M.D., Rochester, Minnesota

Professor of Pediatrics, Mayo Foundation, University of Minnesota and Head of the Section on Pediatrics, Mayo Clinic.

A discussion of some of the conditions which cause blood to appear in the stools of infants and children. This included a consideration of the causes that are operative in early infancy and in later childhood and involves a discusson of hypoprothrombopenia, Meckel's diverticulum, peptic ulcer, chronic ulcerative colitis, polyps of the rectum and colon, esophageal varices, and hemorrhagic diseases.

11:30 **"Public Health and Private Medical Practice, an Unbeatable Team"**

Haven Emerson, M.D., New York City

Member of Board of Health of the City of New York; Emeritus Professor of Public Health Practice, Columbia University; Visiting Lecturer in Public Health, University of Michigan.

Private medicine and public health working hand in hand have brought tremendous benefits to mankind around the world. Public Health supplements private medicine in doing those things which require the power of the police state such as the enforcement of anti-pollution measures, quarantine regulations, and sewage disposal ordinances.

Team play, reciprocal obligations and functions at a professional level, mutual consideration, definition of and respect for the privileges and special competence of the physician to the family and the health officer to the community constitute the elements of success for that particular unbeatable partnership referred to in the title of this paper.

12:00 End of Fourth General Assembly.

INTERMISSION TO VIEW EXHIBITS

Program of Sections

THURSDAY NOON
September 23, 1948

12:00 to 1:30 p.m. (luncheon)

SECTION ON PEDIATRICS

Pan American Room, Book-Cadillac Hotel

Chairman: J. H. Lewis, M.D., Wyandotte
Secretary: R. H. Trimpey, M.D., Lansing

"Xanthomatosis—Christian-Schüller's Disease—and Eosinophilic Granuloma"

R. L. J. Kennedy, M.D., Rochester, Minnesota

A discussion of experiences at the Mayo Clinic with xanthomatosis in infants and children. A summary of important facts regarding incidence, clinical manifestations, diagnosis, treatment, pathology, and prognosis in cases variously described as xanthomatosis, Christian-Schuller's disease, Letterer Siwe's disease, and eosinophilic granuloma.

* * *

SECTION ON SURGERY

English Room, Book-Cadillac Hotel

Chairman: Edward Dowdle, M.D., Detroit
Secretary: D. B. Hagerman, M.D., Grand Rapids

"Portal Hypertension—Treatment by Venous Shunts"

R. R. Linton, M.D., Brookline, Massachusetts

A new chapter is being written in the surgical treatment of bleeding from esophageal varices secondary to portal hypertension due to cirrhosis of the liver and so-called Banti's syndrome.

The selection of patients for the treatment of portal hypertension by means of the various types of venous shunts will be discussed. In the majority of cases the recommended type of operation should consist of a splenectomy and an end-to-side splenorenal vein anastomosis with the suture technic.

A summary of the cases that have been operated upon at the Massachusetts General Hospital and the results obtained to date will be given. The importance of performing the venous anastomosis at the time of the splenectomy will be stressed, since this may be the only opportunity that a satisfactory shunt can be performed.

SECTION ON OTOLARYNGOLOGY

Parlors G-H-I, Book-Cadillac Hotel

Chairman: W. S. Jones, M.D., Menominee
Secretary: W K. Slack, M.D., Saginaw

"Anoxia and Secondary Effects of Respiratory Obstruction"

T. C. Galloway, M.D., Evanston, Illinois

Anoxia and carbon dioxide excess may produce serious and irreversible effects quickly. Its effects must be immediately corrected in respiratory obstruction. Damage to brain tissue, adrenals, heart and other tissue will be discussed as well as symptoms which lead to its recognition. Late mental effects, insanity, depression, et cetera, may be important. These effects may occur from high respiratory obstruction, excessive secretion, anesthesia, shock and other causes.

Respiratory obstruction with associated increased negative intrathoracic pressure may also lead to congestion, exudation, atelectasis, emphysema and so-called atypical pneumonias, pneumonitis, bronchiectasis unless relieved soon. The physiopathology of obstruction will be detailed and its application shown in tracheobronchitis, flame injuries of the airway, bulbar polio, and tetanus.

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SECTION ON OPHTHALMOLOGY

Founders Room, Book-Cadillac Hotel

Chairman: W. Z. Rundles, M.D., Flint
Secretary: Don Marshall, M.D., Kalamazoo

"The Choice of Operation in Paralysis of the Ocular Muscles"

F. H. Adler, M.D., Philadelphia

In the choice of operation for paralysis of the ocular muscles, a number of factors must be taken into consideration. These are (1) the fixing eye, (2) the presence of diplopia, (3) the character of the diplopia (whether it is purely horizontal, or a combination of vertical and torsional diplopia), and (4) the disfigurement. The influence of each of these factors will be explained and an outline offered as a guide in the choice of operative procedures.

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SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Suite 500, Book-Cadillac Hotel

Secretary: O. K. Engelke, M.D., Ann Arbor

"Distinctions Between Personal and Administrative Medicine"

Haven Emerson, M.D., New York City

THURSDAY AFTERNOON

September 23, 1948

Fifth General Assembly

Grand Ballroom, Book-Cadillac Hotel

Chairman: Wilfrid Haughey, M.D., Battle Creek
Secretary: G. C. Stucky, M.D., Charlotte

P.M.

1:30 "Results of a Co-operative Study on the Effects of Streptomycin"

J. B. Barnwell, M.D., Washington, D. C.
Chief, Tuberculosis Division, Veterans Administration

2:00 "Gastric Vagotomy in the Treatment of Peptic Ulcer"

L. R. Dragstedt, M.D., Chicago

Professor of Surgery and Chairman of Department of Surgery at University of Chicago and Attending Surgeon at Albert Merritt Billings Hospital.

The technique of transabdominal supradiaphragmatic section of the vagus nerves for the treatment of peptic ulcer will be described. Four hundred and twenty-five of these operations have been performed to date at the Billings Hospital of the University of Chicago. The indications for the procedure will be briefly discussed as well as the complications and side effects most frequently seen following the operation. A brief resume will be given of the clinical results of gastric vagotomy in the treatment of duodenal ulcer, gastrojejunal ulcer, and gastric ulcer. The advisability of combining gastric vagotomy with other surgical procedures such as gastoenterostomy, pyloroplasty, and partial gastrectomy will be discussed.

2:30 "Thyrotropic Exophthalmos from the Viewpoint of the Ophthalmologist"

F. H. Adler, M.D., Philadelphia

Professor of Ophthalmology, University of Pennsylvania; Consulting Surgeon at Wills Hospital; Member American Ophthalmological Society and American Academy of Ophthalmology and Otolaryngology.

The ocular signs of Grave's Disease are reviewed and a differential diagnosis of thyrotoxic and thyrotropic exophthalmos suggested on the presence of the ocular signs. It is important to differentiate these two types of Grave's Disease because the proper treatment for the thyrotoxic type makes the thyrotropic type worse.

3:00 INTERMISSION TO VIEW EXHIBITS

4:00 "Labor Experiences of Elderly Primigravida" (Based upon 56,392 deliveries)

E. G. Waters, M.D., Jersey City, N. J.

Division Chief of Obstetrics at Margaret Hague Maternity Hospital, Assistant Professor of Clinical Obstetrics and Gynecology, Columbia University.

Henry P. Wager, M.D., Jersey City, co-author

Elderly primipara constitute the group becoming pregnant for the first time beyond the age of thirty-five in the last decade of the child-bearing years. A number of factors are operating to increase the number in the group. Irrespective of the cause of increase, these patients pose problems which involve considerations minimal or non-existant in young primipara. These modify in varying degrees the management indicated during labor and parturition. To determine our position in relation to this group, late pregnancy and parturition experiences in elderly primipara treated in a group of over 55,000 labors were contrasted with those of a comparable group of young primipara (15-25 years). The findings of this study are presented, and furnish a basis for the comments offered. A prognosis is thereby available for pregnancy and labor hazards and possibilities, and preferable methods for delivery in this important and increasing group.

4:30 "Postoperative Thrombophlebitis"

R. R. Linton, M.D., Brookline, Massachusetts

Deep venous thrombosis of the lower extremities following surgical procedures is still one of the unsolved problems in surgery. It is a serious complication both to the extremity and the life of the patient, since death may occur from massive pulmonary embolism. Prophylactice measures should be instituted in all postoperative patients. These should consist in early ambulation, active leg exercises, and the use of the anticoagulants, heparin and dicumarol. Once the diagnosis of deep venous thrombosis or the occurrence of a pulmonary embolus has been detected, the best treatment in our opinion is that the patient should have bilateral femoral vein interruption. In rare instances interruption of the vena cava is indicated.

5:00 End of Fifth General Assembly

5:00 DISCUSSION CONFERENCES IN GYNECOLOGY-OBSTETRICS, MEDICINE, OPHTHALMOLOGY, OTOLARYNGOLOGY, PEDIATRICS, PUBLIC HEALTH AND SURGERY.

(See Page 902)

THURSDAY EVENING
September 23, 1948

P.M.

10:00 STATE SOCIETY NIGHT

An evening of entertainment for all attending doctors of medicine, their ladies and guests. Dancing and floor show. Ballroom, Book-Cadillac Hotel. (Admission by card).

FRIDAY MORNING
September 24, 1948

Sixth General Assembly

Grand Ballroom, Book-Cadillac Hotel

Chairman: F. H. Drummond, M.D., Kawkawlin
Secretary: J. E. Lofstrom, M.D., Detroit

A.M.

9:00 **"How Do You Know Your Patient Is Food Sensitive"**

T. G. Randolph, M.D., Chicago

Instructor in Department of Internal Medicine, Northwestern University Medical School.

Major diagnostic problems in food allergy deal with sensitivity to corn, wheat, milk, eggs, potatoes and other foods taken in oft-repeated feedings; they result in chronic, smoldering symptoms not increased immediately after eating but accentuated in the morning, during the night or late in the afternoon. It is also suggested by itching of nose or throat and profuse mucous production.

Food allergy is the most common cause of perennial rhinitis, perennial asthma, headaches and infantile eczema; a possible cause of any allergic manifestation, including insomnia, chronic fatigue and myalgia.

Skin tests with foods are unreliable. Sharply restricted elimination diets may be harmful. A clinical diagnostic approach is preferable.

9:30 **"The Treatment of Syphilis"**

D. M. Pillsbury, M.D., Philadelphia

Professor, Department of Dermatology and Syphilology; University Hospital, University of Pennsylvania.

Well over a half million patients have now received penicillin therapy for syphilis in the past five years. The answers to some questions regarding the ultimate effectiveness of penicillin for syphilis must await passage of at least two decades, but the enormous experience with the drug to date permits clear-cut answers to many of the chief questions. The following conclusions may be drawn from the evidence to date:

1. Penicillin is far more effective and much less toxic than any other drug available for the treatment of syphilis.
2. Although the optimum schedule for the treatment of early syphilis with penicillin may vary within fairly wide limits, the minimum essential dose and minimum period of treatment have become quite well established.
3. Over 90 per cent of patients with early syphilis may be completely cured by the use of penicillin alone.
4. The initial experience with penicillin was entirely on the basis of patients treated by multiple injections administered in a hospital. However, the available experience with slow absorption vehicles, and the rapid improvement of slow absorption penicillin permits adequate therapy on an out-patient status.
5. The treatment of early and latent syphilis, and of syphilis in pregnancy, has been enormously simplified by a lessened dependence upon toxic drugs, by much less need for technically difficult methods of administration, and by almost complete replacement of prolonged courses of treatment. As a result, the treatment of these and other phases of syphilis has been largely transferred from the office of the specialist and of the large hospital clinic to the office of the general practitioner and smaller clinics, with resultant increased benefits to the population as a whole. It is emphasized, however, that the diagnosis of syphilis, particularly if it is made on serologic grounds alone, is still a matter of considerable difficulty at times. The availability of a non-toxic rapid method of treatment does not justify any relaxation of the necessity for an exact diagnosis before treatment is given.
6. As an aftermath of numerous new infections acquired at home and overseas, during World War II, the incidence of early and late syphilis in practice is at present higher than at any time in the past decade at least. It is probable that no method of treatment, however effective, may be expected to obliterate syphilis entirely as a significant disease in the general population, and that this will be dependent upon the filling in of certain serious gaps in our knowledge of the Treponema pallidum, and in the factors relating to immunity to syphilis in man.
7. Congenital syphilis has become an almost inexcusable medical accident in a population with adequate medical care.

A summary of the data leading to these conclusions is presented.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Practical Office Procedure in Gynecology"**

W. J. Reich, M.D., Chicago

Attending Gynecologist at the Fantus Clinics of Cook County Hospital; Professor Gynecology Cook County Graduate School; Attending Gynecologist at Fox River T. B. Sanitarium; Consulting Gynecologist Hazelcrest General Hospital.

Practical and safe office procedures in gynecology can be of invaluable service to the patient in relation to early diagnosis, proper treatment and in her economic factor.

In the *study of sterility*, following a complete subjective survey of the patient, a careful evaluation of the history and physical examination, the utero-tubal insufflation test (Rubin), the endometrial biopsy study, the pre-ovulatory dilatation of the cervix, the study of the sperm in the vagina and cervix (Huhner Test) are done in the office, clinic or the out-patient department of the hospital.

Chronic cervicitis with ectropion or eversion are best treated by electrocauterization. The endocervical canal is cauterized first, then the ectropion. This is done in one visit. Dilation of the cervix at weekly intervals for four or five times are necessary to prevent stricture.

Trichomas vaginitis is diagnosed on a hanging drop. The therapy consists of the insufflation of a powdered mixture of 20 per cent argyrol, 40 per cent Kaolin and 40 per cent B. Lactose.

Monilia is diagnosed by the hanging drop treated with aqueous solution of 1 per cent Gentian Violet and 1 per cent acriflavin.

Intractable pruritus vulvae of no demonstrable specific etiology in which itching and scratching are very severe responds well to a rectangular injection of the vulva using Zylcaine (Abbott).

Condylmata acuminata of the soft type are treated by 25 per cent podophyllin ointment in a hydrosorb base.

Urethral caruncles which may cause an acending trigonitis or cystitis are best eradicated by electrocautery following procaine block of the urethra.

11:30 **"Good Psychiatry Is Good Medicine"**

C. C. Burlingame, M.D., Hartford, Connecticut

Psychiatrist-in-Chief of the Institute of Living (Neuro-Psychiatric Institute of the Hartford Retreat); Associate in Psychiatry of Columbia University; Editor "Digest of Neurology and Psychiatry."

Until recent years, mental disease, the greatest of all public health problems, was simply accepted, like death and taxes, where people pay and die.

Today, psychiatry, the medical specialty devoted to mental disease, is still suffering growing pains. The very nature of this specialty, as well as its unfortunate use of terminology peculiar to itself, make it the prey of charlatans, and lend it to loose thinking, overclaiming,

and intermingling in the public mind with cultism, faith cures, and metaphysics. These facts, therefore, demand a housecleaning and a more hardheaded differentiation between hypotheses and scientific facts in the field of psychiatry than in any other specialty.

In psychiatry, we have *descriptive diagnosis,* but we are still very short in *disease entities* in the sense that they obtain in physical medicine. However, our improved diagnostic methods auger a time in the not too distant future when we will stop talking about *mental* disease and *physical* disease as two separate entities.

We cannot treat the mind or the body while ignoring the one or the other. There is no physical disease without psychological accompaniments. There are physical disabilities in which emotional factors are primarily the cause. The speaker believes also that there is no emotional or psychological disease worthy of the name unless there be a somatic recording. Evidence to this effect is continually piling up. In the final analysis, researches in laboratories of physical medicine are proving to be of equal or even more significance to psychiatry than are current-day psychological investigations.

Along this same line of thinking, heredity as a cause for mental disease may be largely an expression of our ignorance. Witness the early views regarding paresis, or softening of the brain, which was charged up to heredity until it was found to be syphilis of the brain.

With this burden of proof, common sense dictates that good psychiatry is good medicine, and good medicine is good psychiatry. Psychiatry is not a universal specialty, despite the ventures into "psychiatric aviation." Current-day popularity of psychiatry will subside or largely disappear with little of lasting value accomplished, or else it will be used as an instrument of one of the greatest of medical advances in modern times. The answer rests with organized medicine as a whole.

12:00 End of Sixth General Assembly

INTERMISSION TO VIEW EXHIBITS

Program of Sections

FRIDAY NOON

September 24, 1948

12:00 to 1:30 p.m. (luncheon)

SECTION ON PATHOLOGY

Founders Room, Book-Cadillac Hotel

Chairman: D. H. KAUMP, M.D., Detroit

"Certain Facts of Experimental Embryology and their Relation to Pathological Anatomy"

S. P. REIMANN, M.D., Philadelphia

When pathological anatomy gives a name to a certain condition, whether it be a tumor or some other lesion, the name itself usually has come to imply how the lesion arose, what would have happened if it had not been removed at that time, what the probable prognosis is and sundry other matters. In the case of an autopsy always, but in the case of a surgical specimen also, the relations to other parts of the body are included.

Most diagnoses in pathological anatomy are made with a low power lens. To quote the late, beloved Professor Warthin, the pathologist "needs a power lens and a high power brain."

It is really morphogenesis, the way in which tissues and organs come to be built, which is studied. This fundamentally is the differentiation problem. Several of its phases will be discussed such as cell potency, determination, relative abilities of cells to divide at different levels of differentiation, metaplasia, and differentiation itself in relation to chemical genetics and protein chemistry.

SECTION ON MEDICINE

English Room, Book-Cadillac Hotel

Chairman: G. T. MCKEAN, M.D., Detroit

Secretary: B. B. BUSHONG, M.D., Traverse City

"Amebiasis and Its Complications; Diagnosis and Treatment"

H. J. KULLMAN, M.D., Dearborn, Michigan

Chief of Medical Service, Veterans Administration Hospital, Dearborn, Michigan, and Assistant Professor of Clinical Medicine, Wayne University College of Medicine, Detroit, Michigan.

Today we must be aware of the possible existence of intestinal amebiasis and as the possible etiological factor responsible for liver abscess or pleuropulmonary complications.

Amebiasis may masquerade as chronic malaria, chronic recurring hepatitis, irritable colon or at times chronic ulcerative colitis.

Multiple tests, time permitting, should be accomplished by examining multiple stools, direct visualization by proctosigmoidoscopic examination, roentgen examination of the colon and when hepatic involvement is suspected fluoroscopic examination of the lung fields and diaphragm may be of great value. The white blood count is not helpful enough. The emetine provocative test and specific complement fixation test may be of value.

First of all be aware of this disease, carefully seek the amoeba, adequately treat when found and provide careful follow-up before assuring one of cure.

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SECTION ON GENERAL PRACTICE

Pan American Room, Book-Cadillac Hotel

Chairman: E. M. PETTIS, M.D., Muskegon

Secretary: E. C. LONG, M.D., Detroit

"The Evaluation of Post-Menopausal Bleeding"

W. J. REICH, M.D., Chicago

The evaluation of uterine bleeding after and during menopause offers a challenge in the diagnostic acumen of every physician—be he in general practice or in gynecology alone. The patient is often subjected to various types of trial-and-error treatments, until it is too late for effective therapy. At the Cook County Hospital and the Gynecologic Clinic, the interns, the residents and the graduate students are constantly reminded that bleeding in or about the menopause is carcinoma until proven otherwise. Education must be extended both to the doctors as well as to the patient with emphasis on early diagnosis of malignancy. The patient must be examined every six months for any changes which may occur in her genitalia. The importance of the semi-annual visit to the office should be explained to her in simple layman's language.

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SECTION ON NERVOUS AND MENTAL DISEASES

Parlors G-H-I, Book-Cadillac Hotel

Chairman: H. A. LUCE, M.D., Detroit

Secretary: R. P. SHEETS, M.D., Traverse City

"International Mental Health—The Geneva and London Conferences"

DANIEL BLAIN, M.D., New York City

Medical Director, American Psychiatric Association.

Dr. Blain will report on the European Mental Health Conferences which he covered during the months of July and August, 1948.

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12:00 Radiologists will meet in Suite 500, Book-Cadillac Hotel.

FRIDAY AFTERNOON

September 24, 1948

Seventh General Assembly

Grand Ballroom, Book-Cadillac Hotel

Chairman: C. E. Umphrey, M.D., Detroit

Secretary: J. H. Lewis, M.D., Wyandotte

P.M.

1:30 **"Radical Surgery for Advanced Pelvic Cancer"**

Alexander Brunschwig, M.D., New York City

Attending Surgeon, Memorial Hospital and Professor of Clinical Surgery, Cornell University Medical College.

The standard treatment for carcinoma of the cervix at this time is generally regarded to be irradiation by the use of radium locally and x-ray administered in the form of so-called pelvic cycles. This treatment is capable of effecting cures. To achieve this, however, the disease must be in the earlier stages and localized in the cervix. The fact remains that the majority of women developing cancer of the cervix continue to die of this disease. So firmly has irradiation therapy of cancer of the cervix become established that when this treatment fails to control the disease, repeated attempts are again made with irradiation therapy but once irradiation therapy has failed to control the disease, subsequent treatments of a similar nature are usually ineffective. In the past few decades the advances in surgery have made the risks of laparotomy very much less than in the previous era. Thus the oft-quoted mortality statistics of Wertheim and Bonney, i.e., 15 to 20 per cent for radical operations upon pelvic cancer should no longer be regarded as a deterrent in attempts to remove pelvic cancer surgically. Recent experiences in radical surgry for carcinoma of the pelvic organs in the female, especially carcinoma of the cervix, will be presented and the whole question of the future role of surgery in the attack upon this form of cancer will be discussed.

2:00 **"Pediatric Anesthesiology"**

M. D. Leigh, M.D., Vancouver, B. C., Canada

Director Department of Anesthesiology, the Vancouver General Hospital

Hitherto, blame for many deaths under anesthesia was attributed erroneously to specific anesthetic agents. Now, anesthesiologists feel the majority of deaths from anesthesia on the operating table are due to interference with respiration and are avoidable if basic principles are observed carefully.

A group of these deaths with a discussion of the probable cause of death are presented. These include deaths during tonsillectomy, cleft palate repair, eye wound operations, tracheotomy, thyroglossal cyst, skin graft, appendectomy, and spinal fusion. Other deaths occurring during intrathoracic and neurosurgical operations involve complicated surgical and anesthetic problems and are not discussed in this paper.

2:30 **"Attempts at the Chemotherapy of Cancer"**

S. P. Reimann, M.D., Philadelphia

Director of the Lankenau Hospital Research Institute, and the Institute for Cancer Research in Philadelphia; Associate Professor of Surgical Pathology, Graduate School of Medicine, University of Pennsylvania; Professor of Oncology, Hahnemann Medical College and Hospital.

Attempts at the chemotherapy of cancer use substances that can be divided into four headings.

1. Substances which destroy cells.
2. Substances which interfere with mitosis.
3. Substances which are anti-metabolic.
4. Substances which inhibit growth.

A few examples will be given of each of these. There then follows presentation of results in numerous patients treated with the polysaccharide from Serratia marcescens, as an example of a cell-destroying substance. The results in a number of patients treated with Teropterin, are examples of the use of an anti-metabolite.

The polysaccharide given intravenously destroys parts of tumors but the toxicity is too great to destroy entire tumors without undue risk.

Teropterin has been of palliative help in approximately 10 per cent of patients; in a few it seems there has been an inhibition of rates of growth.

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"Recent Advances in the Surgical Treatment of Peripheral Arterial Disease"**

G. H. Pratt, M.D., New York City

Assistant Clinical Professor of Surgery New York Postgraduate Medical School and Hospital; Chief of Vascular Surgical Clinic, New York Postgraduate Hospital; and Attending Surgeon—St. Clare's Hospital.

With an increase in longevity, many more patients are reaching the age when the complications of degenerating diseases arise. It has been shown that 40 per cent of all adults at the age of forty have signs of arteriosclerosis, and that over 60 per cent of the patients over fifty will die of some vascular complication of the diseases attendent to old age.

It is important, therefore, that the surgical management of the complications of these diseases be known and standardized. This management, particularly of the acute and subacute arterial occlusions, will be detailed. The problem of infection in the extremities when arterio-occlusion occurs and also the treatment of ulcers and gangrene will be described in an effort to point out the therapy most likely to succeed in various stages and at various ages. The advances made in the surgical treatment of these complications by the interruption of the sympathetic system, anticoagulant drugs, conservative surgical measures and changes in amputation techniques will be presented. These changes and the rehabilitation of the amputatee will be illustrated both by slides and by a colored motion picture which will be shown during the presentation of the paper.

4:30 **"Nervous Indigestion"**

W. L. Palmer, M.D., Chicago

Professor of Medicine, University of Chicago

The syndrome of nervous indigestion will be discussed with regard to the respective roles of physical and emotional factors. The varied symptomatology will be outlined. The differential diagnosis of gastritis, gall bladder, dyspepsia, chronic appendicitis, gastrointestinal allergy, abdominal migraine, and the various psychiatric disorders will be considered. The basic principles of treatment will be outlined.

5:00 **DISCUSSION CONFERENCES IN GENERAL PRACTICE, MEDICINE, NERVOUS AND MENTAL DISEASES, PATHOLOGY, PEDIATRICS, SURGERY, AND SYPHILOLOGY.**

(See Page 902)

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END OF SCIENTIFIC ASSEMBLY AND OF 1948 ANNUAL SESSION

Annual Reports

ANNUAL REPORT OF THE COUNCIL, 1947-48

The Council had three sessions of nine days and the Executive Committee convened ten times (to September 18, 1948), a total of thirteen meetings up to the 1948 Session of the State Society. All matters studied and recommendations made by the Society's twenty-five Committees as well as The Council's own thirty Committees and all business of the Society were referred to The Council or to its Executive Committee for consideration, approval, and action. Meetings that formerly ran to five and six hours are now routinely eight to ten hours in length, reflecting the increased activities of the Michigan State Medical Society.

Membership

Members of the State Society, as of July 1 and as of December 31, from 1935 to 1948, are indicated in the following chart:

	1948	1947	1946	1944	1942	1940	1935
July 1	4,645	4,536	4,461	4,615	4,553	4,401	3,410
December 31		4,797	4,799	4,702	4,714	4,527	3,653

The figure for 1948 includes 4,370 active members, 160 Emeritus and Life Members, 12 Retired Members and 103 Military Members. The Society is continuing its wartime practice of according full membership privileges, with remission of dues and assessment, to members in military service; this applies to all members separated from military service during 1948.

Finances

Ernst & Ernst, in their report of December 31, 1947, stated that the accounting procedures and other records are in order. At the September, 1947, meeting of the House of Delegates, the special assessment was continued. The public education program developed with these funds is the best medical public relations program in the nation and is constantly improving.

The aggregate amount of $60,000 was earmarked for the public education fund at the time of the 1946 report. Since that time this reserve for contingencies has been increased to $100,000.

Because of certain implications concerning special assessments, we believe a recommendation should go to the House of Delegates that the special assessment be discontinued and the dues raised to cover this and other vital activities of the Society.

Dr. E. R. Witwer, Detroit, has given the Society many a long hour of services for which we are most appreciative. He has discussed the settlement of the Biddle Estate with the Detroit Trust Company. The Regents of the University of Michigan, who share equally in this estate, elected to have the securities converted to a cash settlement and it is thought it would be wise for The Council to do likewise. The copy of the correspondence on this item together with Dr. Witwer's recommendation is filed for purposes of the record. Certainly our action should be prompt in this matter.

The overcrowded condition at 2020 Olds Tower remains the same. It appears that, in spite of all efforts of our Committee, suitable property in Lansing is not available. If we were to consider building we would immediately incur difficulty because of limited available cash and securities. It would seem that a Building Fund should be created as rapidly as possible. This could be augmented by donations, but the principal source of income would be a portion of the dues.

The financial reports as well as the monthly balance sheets are carefully studied by The Council as a whole or by its Executive Committee. If any member would care to study the many detailed reports of Ernst & Ernst or the monthly balance sheets, their interest and suggestions would be appreciated. Your Society has an excellent financial record.

The Journal

The Publication Committee has published THE JOURNAL for The Council and membership of the Michigan State Medical Society in what it believed was a modern and improved format during the past year. The covers have been an innovation, all different, and all representing some feature of interest to the Society. For the past many months we used the pictures of the living past presidents until all were featured. We then used the Speakers of the House, some of the medical college buildings, and for the past several months have devoted the cover page to committee or other major interests of the Society.

The cover for the January, 1948 number featured some of the speakers of the Postgraduate Institute; the February number was devoted to the Crippled Children's work with the Easter Seal used by the Michigan Society for Crippled Children and Adults; the March number was devoted to the Rheumatic Fever Control program and was sparked by a map of the state with the various centers indicated. In April the work on Cancer was stressed both by the Fight Cancer dagger, and by special articles on cancer. The May Journal was devoted to Michigan's Foremost Family Physician, with a drawing of Dr. DeGurse superimposed on his scroll. The June number featured THE JOURNAL and its production. Special covers are being designed for the balance of the year. We believe that our covers for many months have been especially interesting and will continue to be attractive.

THE JOURNAL was established in 1902 to carry to our members the most of interest and of professional and economic education. We have tried to follow that plan and to use its columns to impart the ideals and interests of the Society, also to inform our members of the trends in medicine, science and sociology. Times are changing and to be alert is of utmost importance.

If we have kept our members in the van of progress, we have well discharged our duties.

Organization

Organization among the fifty-five component county or district medical societies continues to be satisfactory. A number of county societies are offering unusually fine postgraduate "clinic days" with programs worthy of presentation by national medical societies.

One county (Berrien) held an "Organization Seminar" last November. Such a meeting—in the nature of a round-table discussion, attended by MSMS officers—is worthy of emulation throughout the State and should be arranged by county society officers. *A recommendation on this subject follows.*

The County Secretaries-Public Relations Conference of January 25, 1948, at the Book-Cadillac Hotel, Detroit, attracted a record group of county society secretaries, legislative and public relations keymen, representatives of the Woman's Auxiliary, and also state and county health officers (invited for the first time). An outstanding program in medical economics and public relations was offered these leaders of their respective county and district organizations.

The Michigan Delegates to the AMA House of Delegates continued to perform remarkable service in forwarding the interests of medical practitioners of the nation. The MSMS Public Relations Counsel aided the Dele-

gates in their outstanding job of making friends for Michigan in the national organization.

In like manner, the MSMS officers who attended the AMA Sessions in Cleveland, January, 1948, and in Chicago, June, 1948, continued to make valuable contacts among AMA officers and in ancillary groups. Their presence at these sessions has resulted in assumption of leadership by Michigan's representatives in national organizations, such as the Associated State Postgraduate Committee, National Conference on Medical Service, Co-operative Medical Advertising Bureau, AMA Conference of County Society Officers, Conference of Presidents and Other Officers of State Medical Associations and the Medical Society Executives Conference. Michigan's influential position is due to the self-sacrificing contribution of effort and time on the part of MSMS Officers and Delegates; their activity in national medical affairs safeguards the interests of Michigan's practitioners of medicine.

The second Michigan Postgraduate Clinical Institute was held March 10-12, 1948, in Detroit. A total of 1,462 registered at the Institute which gained over 28,000 lines of publicity in Detroit and Michigan newspapers. The scientific program, presented exclusively by Michigan doctors of medicine, was outstanding and attracted medical registrants not only from Michigan but from Indiana, Ohio, Wisconsin and Ontario.

MSMS officers attended numerous Michigan county and district medical society meetings during the year and were guest speakers before the state medical societies of Indiana, Illinois, South Dakota, West Virginia, and Wisconsin. Their presentations before lay groups, clubs and organizations throughout the year totaled several scores of appearances—with messages beamed to the theme that voluntary medicine has achieved great results in this State for the people's benefit and is to be preferred to a compulsory federally operated type of medical service.

Public Relations Program

The MSMS Public Relations program has "come of age." The framework has proved sound and the addition of details has rounded it into a strong, far-reaching effort. The Michigan program has inspired emulation by other state medical societies and has been used nationally both in its entirety and in its detail. It has gained for MSMS a position of health leadership in the eyes of the people of Michigan.

A volume would be necessary to review the work and planning involved in this Program. Here are some of the highlights of 1948:

Newspapers. *Advertising*—4 ads, 49 daily, 56 weekly papers and the Michigan Farmer. Reading circulation 1,750,000. *Feature Releases*—3 column to full page in size, pictures used, one issued each month. *News Releases*—One weekly Health News Column on mats to all weekly papers. News coverage of state assemblies, conferences, awards, activities, etc. Feature articles and pictures in state and national magazines.

Cinema. *"Lucky Junior,"* 10-minute film on immunization and disease control prepared and sponsored by MSMS, produced by Jam Handy Organization, released through motion picture theaters. *"Be Your Age"* Metropolitan Life Insurance Film sponsored in Michigan by MSMS, ends with facts re MSMS Rheumatic Fever Control Centers. 80,000 "Your Child is Safer in Michigan" pamphlets distributed by theatres in connection with picture.

Radio. *"Tell Me, Doctor"* 5-minute, daily, health news, 22 Michigan stations, 5,720 separate broadcasts. Used on 11 stations by other medical societies. *"Medical Talks"* by U. of M. and MSMS, 15-minute weekly, 9 stations, 351 broadcasts. Encouragement and health with several county and local regularly scheduled broadcasts. Special-events broadcasts and news releases to stations.

Publications. *Medical Associates Brochure*—review of each vocation, with pictures, distribution—schools and interested organizations. *Michigan Rural Health Conference*—Report on first Conference, distribution—state and national organizations. *P.R. Bylines*—monthly bulletin to members. *Journal*—"P.R. in Practice" column. Special feature in each issue reprinted and sent to Legislators. *Woman's Auxiliary P.R. Plan*—guidance to county medical society auxiliaries. *Medical Plan for Michigan*—outline of Medical Organizational activities in Michigan.

Education. Course on Sex Education, dramatized—transcribed by Wayne University. Distribution in high schools of Michigan.

Display. Window display—Boston Store, Grand Rapids, Booth display—Jackson County Fair, AMA Scientific Exhibit in Chicago.

Public Speaking. Average of one speech per week before lay groups.

Awards. Four "Outstanding Health Service" Awards. One to Michigan's Foremost Family Physician. One nomination for AMA Gold Medal for General Practice. Fifty Year Club established.

Liaison. Michigan Health Survey—Health Survey Advisory Committee, Michigan Rural Health Conference—Committee on Rural Medical Service, Legislative activity, Public Relations Conference, Michigan Health Council, Statements of Policy, Commission on Health Care, with all of whom the P.R. department worked closely, are reported elsewhere.

Liaison in forwarding publicity was established with the Michigan Foundation for Medical and Health Education, Inc., Michigan Society for Crippled Children and Adults, Inc., the Cancer Control Committee and national organizations.

To carry on this activity and to allow increasing personal contact with the many local organizations, newspapers, radio broadcasters, etc., in their home communities, The Council authorized the employment of Walter H. Corsette to assist Hugh W. Brenneman, Public Relations Counsel. The Public Relations Committee has used the advertising counsel of Wallace-Lindeman, Inc., of Grand Rapids, as well as the Jam Handy Organization of Detroit as consultant in visual and auditory aids. Plans for 1949 have been developed calling for the continuance of this program and increasing participation in health and civic organizations by Michigan's doctors of medicine.

Committees

A total of fifty-five Committees functioned during the past year to aid the membership in the study of important matters and current problems facing the medical profession. The enlightening Annual Reports of these active groups will best portray their unusually high accomplishments of the past twelve months. The members of these many Committees deserve sincere gratitude for their time-consuming efforts in behalf of all medical practitioners of this State—they are responsible for the continuing progress of the Michigan State Medical Society.

Some of the more active committees included:

1. The *Committee on Scientific Work* arranged the excellent program for the 1948 Annual Session in Detroit. Best evidence of the many months of preparation spent by this hard-working Committee is the three-day postgraduate course to be enjoyed by those who will register at the MSMS Annual Session.

2. The *Public Relations Committee* headed by L. W. Hull, M.D., Detroit, continues to be most productive of new, successful projects created to make friends among the laity for the medical profession.

3. The *Cancer Control Committee* accomplishes much in this State by its unified program (all cancer groups in Michigan working as one). The Committee under the Chairmanship of N. F. Miller, M.D., Ann Arbor, is doing an effective job with the public as well as with the medical profession.

4. The *Venereal Disease Control Committee* (L. W. Shaffer, M.D., Detroit, Chairman) is a progressive group whose outstanding co-operation with state agencies and

lay organizations achieves unusual results in the group's aim to control the spread of venereal infection.

5. The work of the *Committee on Study of Medical Practice Act* involves so many problems that the MSMS Council instructed it to limit its studies to the medical practice acts of Michigan and other states, with a view to developing a model state medical practice act, if necessary. The MSMS General Counsel has been authorized to aid this Committee by contacting the American Medical Association and making a study covering AMA research in the Medical Practice Laws and Basic Science Acts of all states. The majority opinion of the Committee on Study of Medical Practice Act is that the present Medical Practice Act of Michigan is adequate for the medical profession and the public at the present time and any major manipulation of this law might disturb its present favorable provisions as well as affect court decisions based on the Act and its amendments.

6. The *Advisory Committee to the Woman's Auxiliary* is to be commended on the increased activity of the Auxiliary during the past twelve months. The work of the Woman's Auxiliary, under the capable leadership of President Mrs. T. Grover Amos, Detroit, in such projects as the Rural Health Conference, the Easter Seal Sale, and Health Month (March) have given new life to the woman's Auxiliary, with resulting benefit to the organization, the medical profession, and the public. During the past few months, an extraordinary job was done by the Woman's Auxiliary in its development of a comprehensive public relations program.

7. The monumental work of the *Committee on Constitution and By-Laws* during the past year is being referred to the 1948 House of Delegates in the compact shape of a proposed full revision of the MSMS Constitution and By-Laws. This graphically bespeaks the hard work of this Committee, headed by T. K. Gruber, M.D., Eloise.

8. A new committee, the *National Emergency Medical Service Committee*, has developed a program of medical service in case of emergency due to atomic warfare, for presentation to State of Michigan officials. This Committee and its Chairman, H. F. Becker, M.D., Battle Creek, are to be commended on their foresight and should be given all help in the major job of medical preparedness.

9. The *Annual Report of the Rheumatic Fever Control Committee* indicates the increasing scope of this important Committee's activities and its need for a full-time medical co-ordinator. Commendation for wholehearted co-operation in the work of this Committee goes with sincere thanks to the Michigan Society for Crippled Children and Adults, to the Michigan Crippled Children Commission, and to the Alpha Phi Sorority.

10. The *Committee on Courses in Medical Economics* conducted a series of lectures in the University of Michigan Medical School, November-December, 1947, and April-May, 1948. The lecturers were Wilfrid Haughey, M.D., Battle Creek, R. L. Novy, M.D., Detroit, and John R. Rodger, M.D., Bellaire; in addition, three lectures on the business side of medicine were presented by Henry C. Black of Professional Management, Battle Creek.

Wayne University College of Medicine also features lectures in medical economics presented by MSMS Officers; arrangements have been made to open these lectures in October, talking to the freshmen—it being felt that by instructing the freshmen best results are obtained since the upperclassmen already have formed plans and opinion and might not be as responsive.

11. Permanent Conference Committee with Michigan Hospital Association, Michigan State Nursing Association, and Michigan State Pharmaceutical Association. The Committee reported as follows:

"The Committee held two meetings during the spring of 1948. The representatives of the Michigan State Medical Society were authorized to enter this conference to study problems of nursing care. At the initial meeting, it was found that the majority of the other two groups wished to broaden the scope of this conference to include all problems of mutual importance. The Council subsequently granted permission to the representatives of the MSMS to participate in the conferences for discussion of all mutual problems. At the second meeting, several mutual problems were discussed and a formal request for a suggested agenda for discussion was made by the chairman. A third meeting was requested for June but was cancelled because the representatives of the Michigan State Nursing Association were unable to attend. In the second conference, it was agreed that all mutual problems would be discussed and a report made to the parent organizations before any public announcements were made on the subject. In the June issue of the *"Michigan Nurse,"* a public printed demand on the hospitals was made. This matter must have been in preparation for print at the time the two conferences were held this spring and were never discussed or called to the attention of the entire group. This action has been invited to the attention of the nursing organizations with the expectation that we shall receive more favorable co-operation in future."

12. The outstanding work among the states of the union of our MSMS *Committee on Postgraduate Medical Education* is best exemplified by the honor conferred on Michigan in Chicago on June 23. E. F. Sladek, M.D., Traverse City, MSMS President-Elect, and H. H. Cummings, M.D., Ann Arbor, Chairman of the Postgraduate Medical Education Committee, were chosen as President and Secretary-Treasurer, respectively, of the Associated States Postgraduate Committee, representative of all state medical societies doing a modern job in postgraduate medical education.

13. The *Committee on Dues Structure* reviewed the dues of other state medical societies as well as those of component county medical societies in Michigan; also the financial needs of MSMS were considered along with the contemplated program of society activities in the future. To insure no diminution in the services desired by and rendered to MSMS members as well as those given over the years to the public, the Committee on Dues Structure recommended "that the annual dues of the Michigan State Medical Society be fixed at twenty-five dollars, and that for the coming year, if an assessment is necessary to augment the funds of the Society, such assessment shall not exceed twelve dollars." *A recommendation on this subject follows.*

14. *Liaison Committee with Michigan Hospital Association.* The purpose of this Committee—which has met twice during the past year—is to discuss and advise the parent organizations on all problems involving both hospital and medical care and to formulate plans for concerted action with the approval of the governing bodies.

The following points have been under discussion during the year: (a) The mechanics of the meetings of this Committee; (b) The relation of both groups to the Michigan Crippled Children Commission; (c) The Blue Cross-Mercy Hospitals problem; (d) Information from the hospital planning conference held in Chicago; (e) Information from the National Health Conference (Washington, D. C.); (f) Veterans Trust Fund—1. hospital care; and, 2. medical care and fees; and, (g) Nursing problems—State Board of Registration Advisory Committee.

Contacts with Governmental Agencies

The Michigan State Medical Society not only continues but has augmented its important contacts with many governmental agencies, both federal and state. Chief among these during the past year were:

1. *Contacts with U. S. Senators and Congressmen in Washington, D. C.* Pursuant to instructions of the 1947 House of Delegates, The Council dispatched three MSMS representatives to confer with Michigan's Congressional Delegation in Washington on April 26-27. These personal contacts with Michigan's two outstanding Senators and its Congressmen, many of whom are leaders in the House of Representatives, continues to foster much good will on behalf of the Michigan medical profession.

In this connection, the medical profession's vigorous protest against the special call for doctors of medicine up to 45 years of age, a definite discrimination in the proposed draft bill, was effective; subsequently, this objectionable clause was rejected by Congress.

The Council reports a very gratifying meeting with

Senator Arthur H. Vandenberg in Grand Rapids, October 30, 1947, on which occasion Michigan's illustrious senior Senator gave great praise to the Michigan medical profession for creating Michigan Medical Service which he termed "Michigan's greatest public trust."

2. *The Michigan Legislature,* in a two months' special session in the spring of 1948, handled a bill of major concern to the medical profession: an amendment to the Hospital Survey and Construction Act to meet the requirements of the Federal law; a clause safe-guarding the medical profession from regulation was included in the Michigan Act by the Legislature, at the request of the Michigan State Medical Society.

Hospital Licensing Bill. A special committee of The Council was appointed to study the proposal for a hospital licensure act covering *all* Michigan hospitals. The Committee was present at a conference in Lansing with representatives of the Michigan Hospital Association, State Department of Health and other groups where the proposed amendments to accomplish a complete hospital licensing program were studied. The MSMS Committee does not approve of any legislation so far prepared. Its report reads: "If a licensing board is created, it must have a sufficient purpose. Hospitals are now approved by old and well-established organizations and well regulated and under established procedures. Hospitals too small for those examinations need regulation only by sanitary and fire authorities. They are too small to qualify for other benefits which would be provided by a special new licensing provision."

3. The *Michigan Crippled Children Commission* and the *Michigan State Medical Society* continue their fine mutual relationship which has existed for many years—due primarily to the co-operation and understanding of Chairman Emmet Richards, Alpena, R. V. Walker, M.D., Detroit, the other members of the Commission, and its Medical Director, Carleton Dean, M.D., Lansing. The Commission's co-operative work in the MSMS Rheumatic Fever Control Project is especially praiseworthy.

4. *Michigan Department of Health.* The usual number of contacts were made during the past year with officials of the Michigan Department of Health, many of whom, including the Acting Commissioner, were routinely invited to meetings of The Council, its Executive Committee, and to the other preventive medicine committees of the State Medical Society.

By invitation, The Council appointed an Advisory Committee to the Bureau of Maternal and Child Welfare of the Michigan Department of Health, which committee, chairmaned by Frank VanSchoick, M.D., Jackson, held one formal meeting at which the director of each division of the Bureau presented the sphere of activity as related to his specialty; with this background, the Committee was able to advise the Bureau on matters of policy and concerning details in our mutually overlapping fields. The liaison was extremely friendly and the Committee felt that a new era of satisfactory endeavor in health problems and administration could be worked out in the American way. Through correspondence, the Committee has advised the Bureau on many problems and in reviewing and assisting in editing the Bureau's publication on "Nursery Standards and Techniques."

5. *Basic Science Act.* A Special Council Committee, headed by President P. L. Ledwidge, M.D., was appointed to confer with representatives of the Michigan State Board of Registration in Medicine and the Board of Examiners in Basic Sciences. He attended a hearing on administrative rules of the Basic Science Board held in the Senate Chambers at Lansing, upon invitation of Colon T. Smith, Chairman of the Senate Committee on Rules and Regulations of State Boards and Commissions. Since that time, upon advice of the Executive Committee of The Council, President Ledwidge has worked with the Governor's office in an effort to improve the application of the Basic Science Act. Largely through the work of H. H. Warner, Special Counsel to Governor Sigler, reciprocity with Iowa has been established, and reciprocity with all other states having basic science laws is now being studied.

At its October 14, 1947 meeting, the State Board of Registration in Medicine changed its administrative rules to permit postgraduate students to take up to three years' training in approved hospitals, without a license to practice; however, in February, 1948, the Secretary of the Board reported that he had received a ruling from the Attorney General that the Board did not have authority to grant this permission. This whole matter needs clarification which should be attempted by legislative action, unless corrected by other means in the immediate future.

6. *Michigan Department of Public Instruction.* A Liaison Committee with the State Department of Public Instruction was formed whose advice was sought in two major projects: (a) in the development of standards for the practical nurse training program; and (b) on standards for medical office assistants.

7. *State Vocational Rehabilitation.* During the past year, MSMS approved the request of State Vocational Rehabilitation for medical consultation service in rehabilitation work. The plan of medical consultants in various parts of the state will give Vocational Rehabilitation needed local medical advice in problem cases.

Contacts with Non-governmental Agencies

1. *Michigan Hospital Service—Mercy Hospitals Matter.* A special committee of The Council, headed by Wm. A. Hyland, M.D., Grand Rapids, was appointed in July, 1947, to meet with the Reverend Mother of the Sisters of Mercy and with the heads of Blue Cross in Michigan to discuss the differences between the two organizations. The first meeting was held in August at Mercy College in Detroit, attended by Mother Raymond, Sister Carmelita, Director of Hospitals for the Mercy Order, and Sister Bernard, Counselor of the Order. Representatives of the Blue Cross were Mr. Wm. S. McNary and Mr. J. C. Ketchum; representatives of the Michigan State Medical Society were Drs. Wm. A. Hyland, P. L. Ledwidge, Wilfrid Haughey, P. A. Riley, L. J. Gariepy, and Mr. Wm. J. Burns; in addition, several members of the Michigan Hospital Association were present. A discussion was held during which the points of difference were brought out. Questions were offered from all sides, which necessitated adjourning to a later date, in order for the questions to be taken up with the board of each group. The Sisters were most cordial, the Committee being appreciative of their thoughtfulness in providing refreshments.

The second meeting was held in November with the same group meeting with the exception of the Sisters, who were represented by Mr. Joseph F. Verhelle, one of their advisors. The discussion of the previous meeting was reviewed and the many questions brought up were answered to a great extent. At the conclusion of this meeting the Chairman felt that a smaller group located in Detroit could carry on the matter, as all being in the area, they could be more conveniently gathered for discussion. Therefore, Dr. Ledwidge, Mr. Ketchum, and Mr. McNary, representing the Michigan State Medical Society, Michigan Medical Service, and Michigan Hospital Service with Mr. Verhelle, representing the Sisters of Mercy, were authorized to continue the matter.

2. *Michigan Medical Service* continues to serve the medical profession and the public and to maintain its standing as the largest voluntary medical service health plan in the world; among the states, it is the leading bulwark against compulsory programs to regiment medicine.

3. The Michigan Society for Crippled Children and Adults continues to underwrite Michigan's unique Rheumatic Fever Control Program with a grant to the Michigan State Medical Society of over $21,000 annually. Twenty-nine Rheumatic Fever Centers (sixteen in Wayne County) are now in operation—some in their third year. Recognition of outstanding co-operation by President Emmet Richards of Alpena and Executive Director P. C. Angove, Detroit, is gratefully recorded.

4. *Michigan Foundation for Medical and Health Edu-*

cation, Inc. This Foundation, sponsored by the Michigan State Medical Society and headed by E. I. Carr, M.D., Lansing, has established a student loan fund to encourage young physicians to practice in rural areas and has developed ways and means of raising, establishing, and administering this important fund.

A recommendation on this subject follows.

5. The second *Rural Health Conference,* scheduled for September 17-18, 1948, represents the joint co-operation of the Michigan State Medical Society and forty groups all interested in rural health. No better public relations for the medical profession exists than this Rural Health Conference which should be established as an annual meeting, sponsored by the Michigan State Medical Society with the aid of other interested health and lay groups. The MSMS Rural Health Committee, of which H. B. Zemmer, M.D., Lapeer, is head, is aided in this important project by the MSMS Public Relations department.

6. The Michigan Health Council has revived its activities and, in conjunction with some twenty other health and lay agencies, is planning an augmented program for the future. The Council wishes all success to the Michigan Health Council, especially in its important work of encouraging community health councils throughout the State.

7. *Michigan Association of Health, Physical Education, and Recreation.* The MSMS co-operated with this Association by furnishing a medical speaker at its Grand Rapids Convention of February 20, 1948. This important contact will be continued.

8. *Michigan Parent-Teacher Congress.* An official MSMS representative was appointed to the Health Committee of the Michigan Parent-Teacher Congress, as of the first of 1948. The Congress is co-operating with the Michigan Rural Health Conference and the program of the Michigan Health Council.

9. *Michigan Hospital Association.* An MSMS representative addressed the Traverse City Conference of the Michigan Hospital Association in November, 1947, as a direct result of which the Liaison Committee of Michigan Hospital Association—Michigan State Medical Society, was created. Increased co-operation between these two organizations was evidenced by the joint meeting of the Michigan Hospital Association Board of Trustees and the MSMS Council, held in July, 1948, at which mutual problems of important concern to the professions of medicine and hospital management were discussed. The threat of federalized control affects hospitals even more strongly than it does the medical practitioner, a fact which is recognized by the leaders of both groups.

10. *Michigan State Pharmaceutical Association and State Bar of Michigan.* During the past year a liaison committee with the Michigan State Pharmaceutical Association was created, upon request of the Michigan State Pharmaceutical Association; a similar representative committee called the Medical Jurisprudence Committee has been in existence as a committee of the State Bar of Michigan for several years. Co-operative discussions and activity bring beneficial results to the memberships of all these allied groups.

11. *National associations* contacted in various ways during the past year were: (a) American Cancer Society, to which an MSMS representative was appointed; (b) American Red Cross, which sent its Medical Director to Michigan to attend a meeting of the MSMS Committee on Blood Banks; (c) United Mine Workers, whose Medical Director aided MSMS in discussions on union health funds; (d) National Conference on Medical Service, to which Michigan was host in Chicago on February 8, 1948, at its 21st Conference, and which was the best attended Conference ever held by this organization; (e) American Heart Association, to whom the Michigan State Medical Society addressed the following statement of policy:

"Increased financial support for study and care of heart disease, of which rheumatic fever is a prominent part, is desirable.

"A national campaign to support this work is in preparation. The pioneering experience of the MSMS warrants that in any such program in this state, the MSMS should constitute the body through which the activity should be channeled, and that funds accruing from any campaign for the above-mentioned purposes be utilized under the direction of the Rheumatic Fever Control Committee and other appropriate committees of the MSMS in the expansion and furtherance of their programs.

"This statement is contingent upon the understanding that a major portion of any funds raised in this state as a part of a national campaign shall remain in this state."

12. *American Medical Association.* The Council expresses its appreciation to the parent organization for many and miscellaneous services performed on behalf of MSMS and its individual members during the past year, especially by its Bureau of Legal Medicine and Legislation and the Council on Medical Service. The Council regretted the AMA's extempore action re health care coverage of its employes and as a result instructed Michigan's Delegates to the AMA to initiate or join in action in the AMA House of Delegates to correct this error, which we feel represented the worst type of public relations. It is gratifying to report that the AMA House of Delegates adopted the Michigan Resolution; our State's eight Delegates, including R. L. Novy, M.D., Detroit, are to be thanked for their efforts with this resolution which ends the present arrangement at the expiration of the one-year contract.

New Projects and Miscellaneous Activities

1. *Immunization Month* (February, 1948) was created by the Michigan State Medical Society as a voluntary program to demonstrate that Michigan's practicing doctors of medicine and official health agencies can successfully carry out a co-operative effort to reach and protect every child in Michigan regardless of economic status; this program to control and eventually eradicate small pox, diphtheria, whooping cough and tetanus, dramatically proved that the medical profession united in humanitarian efforts can accomplish any program for the good of the people by *voluntary* self-developed methods. It is hoped that Immunization Month will be an annual event. The projection of this ambitious state-wide program necessitated a special meeting of the Executive Committee of The Council and lengthy discussions at four additional sessions.

2. *Survey of Rural Health Needs.* A momentous by-product of the first Rural Health Conference is the survey of rural health needs in Michigan, inaugurated in the spring of 1948. This is a co-operative effort of the Michigan State Medical Society, the Michigan Foundation for Medical and Health Education, and the Social Research Service of Michigan State College. The objectives are indicated in the formal contract between Michigan State Medical Society and Michigan State College: "to determine the extent of medical needs among a sample of families in the State of Michigan, and in at least one rural community of Michigan; to obtain data on attitudes, opinions, and practices of members of the sample population pertaining to health and health care; to prepare such material as may be necessary to yield efficient and economical samples of families in the rural portions of Michigan, both on a community and on a state-wide basis." The survey will take one year and should be replete in public relations opportunities, of benefit to both the medical profession and the public it serves.

3. *Membership Month* (April, 1948) was instituted at the suggestion of President P. L. Ledgwidge, M.D., and resulted in the certification to the American Medical Association of 262 new MSMS members in the various classifications (including military).

4. During the past year, The Council developed statements of policy on immunization, on venereal disease control, on making cancer a reportable disease, on rheumatic fever control, on Rh testing by state health department, and on community health centers. These important pronouncements are appended to the body of the Annual Report of The Council.

Recommendations

The Council recommends:

1. That the House of Delegates again urge, with emphasis, that all component county and district medical societies—which have not already taken effective action—should make every effort at the earliest possible moment to negotiate necessary revisions in schedules of benefits covering governmental wards so that individual members of county or district societies are not penalized by being forced to perform services at a financial loss and below the fees either charged private patients in their particular area or those indicated in the Uniform Fee Schedule for Governmental Agencies. (The county contractual clause in the Afflicted-Crippled Children Acts limit the Michigan Crippled Children Commission, by law, to payment of the county fee, where it is *less* than the Michigan Crippled Children Commission fee schedule.)

2. That the Michigan Foundation for Medical and Health Education, Inc. receive greater help and financial support from doctors of medicine in Michigan, to the end that the profession shall show the public and health-minded laymen that it is leading the way in this salutary endeavor. Only in this way will laymen become interested in making substantial contributions to the Foundation.

3. That Organization Seminars be arranged by county and district medical societies in all parts of Michigan during the ensuing twelve months. Through these local meetings the officers of the Michigan State Medical Society can bring to the membership—in an intimate, personal manner—confidential information on the state of the profession.

4. That the annual dues of the Michigan State Medical Society be set at Thirty-five dollars per capita for the year 1949.

Respectfully submitted,

O. O. Beck, M.D., *Chairman*
W. E. Barstow, M.D., *Vice Chairman*
C. E. Umphrey, M.D.
P. A. Riley, M.D.
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
T. E. DeGurse, M.D.
E. A. Oakes, M.D.
F. H. Drummond, M.D.
R. H. Holmes, M.D.
A. H. Miller, M.D.
W. H. Huron, M.D.
D. W. Myers, M.D.
E. A. Osius, M.D.
J. S. DeTar, M.D.
P. L. Ledwidge, M.D., *President*
E. F. Sladek, M.D., *President-Elect*
L. Fernald Foster, M.D., *Secretary*
A. S. Brunk, M.D., *Treasurer*

Statement of Policy re Immunization

"Immunization should be done in the first year of life and booster shots should be administered thereafter; the economic status should not be a hindrance to every child being immunized by his family physician. This also refers to diphtheria, whooping cough, tetanus and smallpox."

Statement of Policy re Venereal Disease Control

"It is the responsibility of the physician to discover venereal disease and to report the existence of that disease to the State Department of Health in accordance with existing law."

Statement of Policy re Making Cancer a Reportable Disease

"Cancer is not a communicable disease and nobody is in jeopardy when it is not reported; and further such reporting will violate the privileged communication between patient and physician."

"The Policy Committee of the Michigan Pathological Society recognizes that there are a number of advantages in making cancer a reportable disease, particularly since it appears necessary as a preliminary step to setting up any type of cancer registry.

"However, it is the opinion of the committee that no such step should be taken until a suitable medical body, working with the State Medical Society, the State Board of Health, and the State Pathological Society, could be established.

"It is recommended that the methods used in gathering cancer statistics and reporting cancer cases in Massachusetts, Pennsylvania, Connecticut and New York be studied before a definite step toward making cancer reportable or setting up a state-wide registry be attempted."

Statement of Policy re Rheumatic Fever Control

"Increased financial support for study and care of heart disease, of which Rheumatic Fever is a prominent part, is desirable.

"A national campaign to support this work is in preparation. The pioneering experience of the Michigan State Medical Society warrants that in any such program in this state, the Michigan State Medical Society should constitute the body through which the activity should be channeled, and that funds accruing from any campaign for the above-mentioned purposes be utilized under the direction of the Rheumatic Fever Control Committee and other appropriate committees of the Michigan State Medical Society in the expansion and furtherance of their programs.

"This statement is contingent upon the understanding that a major portion of any funds raised in this state as a part of a national campaign shall remain in this state."

Statement of Policy re Community Health Centers (Broad principles only)

"The Michigan State Medical Society recognizes the demand for better facilities to meet the medical needs of certain areas of the state.

"Whether so-called health centers are to afford even a partial solution of the problem must depend in large measure on two considerations: one, a clear definition of the scope and nature of their functions; and two, the type of control by which their operations are to be governed.

"Approval of health centers by The Council of the Michigan State Medical Society should be expected only when their purposes are consonant with the well established democratic principles of private enterprise as applied to the practice of medicine, and whenever the control of their operations is vested in private practitioners of medicine and civic and health agencies of the local community."

Statement of Policy on Rh Testing by State Health Department

"The Committee on Policy agrees with the suggestion of the Executive Committee of The Council of the Michigan State Medical Society that Rh testing by the Michigan Department of Health be limited to those instances where this service is not available in the local community and where the patient is unable to pay for it.

"It is the opinion of the Policy Committee that Rh testing is only a small part of the service required in connection with the problem of erythroblastosis. Many times the Rh testing of the woman alone is entirely inadequate, as pointed out by Dr. Levine at the last meeting of the Pathological Society. This laboratory work should be part of a Medical Community Laboratory Service which is prepared to test both mother and father

for the various subgroups and sensitization against the four standard groups. Further, this service should be available when the erythroblastotic baby is born so that proper checks can be made and proper blood used in the exchange transfusion of the child if desired.

"Further reason for having the work done locally is that the local physician or obstetrician needs the complete report so that he can handle the patient and the baby intelligently."

ANNUAL REPORT OF COMMITTEE ON RURAL HEALTH, 1947-1948

The Committee on Rural Health held four meetings during the past year: on November 10, 1947, December 11, 1947, February 25, and July 14, 1948, both in its normal capacity and as the Health Survey Advisory Committee.

This committee, in directing its efforts toward solving various medical problems confronting rural areas at the present time, concentrated mainly on discussions of the following items:

1. *Michigan Rural Health Conference.*—The first annual Michigan Rural Health Conference was enthusiastically received by all who attended. Held on September 18-19, 1947, on the campus of Michigan State College, East Lansing, Michigan, the program attracted representatives from scores of organizations interested in improving rural health and medical care. The Conference was sponsored by the Michigan State Medical Society in cooperation with twenty-nine other health and lay organizations. Subsequently, a brochure was published by the Michigan State Medical Society outlining the work which was accomplished at the Conference and distributed to all co-sponsoring organizations and their members. Copies of the brochure were also furnished the National Congress of Parents and Teachers, Woman's Auxiliary to the AMA, all state superintendents of education, leading farm organizations, National Grange, Milk Co-operative, Farm Bureau, U. S. Public Health Service, Farmers Union, deans of all medical schools, the American Country Life Associations, and other interested groups; these booklets were also distributed to visitors at the MSMS exhibit at the AMA Convention in Chicago.

A second annual Michigan Rural Health Conference is scheduled for September 16-17, 1948, and will again be held in the halls of Michigan State College. Forty organizations will join with the MSMS in co-sponsoring this year's Conference as contrasted to twenty-nine last year. Sixteen discussion groups will be utilized at the current Conference which will allow a wider scope than the four groups used in 1947. These groups will report as panel discussions to encourage greater audience participation. Over 500 people are expected to attend the 1948 Conference.

2. *Michigan Health Survey.*—Conducted by the Social Research Service of Michigan Sate College under the sponsorship of the Michigan State Medical Society and the Michigan Foundation for Medical and Health Education, Inc., this survey is designed to show the extent of medical needs in Michigan from a representative sample of families. Procedure for the survey is based upon charts and master sampling techniques developed by Iowa State College and a medical needs schedule developed by the Sociology and Anthropology Department of Michigan State College validated through work by doctors of medicine loaned by the University of Michigan Medical School. According to this master plan, the survey will be taken from a representative cross-section of urban and rural households throughout the state. In addition to determining the medical needs, the survey is designed to obtain data on the attitudes, opinions, and practices of members of this sample population pertaining to medical and health care. Further information on voluntary health service plans and hospitals will also be obtained. Seven Michigan State College professors assisted the Committee in drawing up and testing the 180 survey questions which are divided into three parts: (1) medical needs schedule, (2) practices and opinions regarding health services, and (3) control items. This Committee is well satisfied with the work of the survey to date and feels that the information to be made available upon its completion will be of value in promoting the health of the people of rural Michigan.

3. *Federal Hospital Survey and Construction Act and the Michigan Implement Under House Bill 451 of 1947.*—This law, designed to subsidize state planning programs for the extension of hospital facilities and to assist in the construction of hospital facilities, can do much to raise the standards of rural health. Approval of the state plan by the Surgeon General of the United States makes Michigan eligible to receive $2,171,000 a year for five years to assist local communities in developing adequate hospital facilities. Two-thirds of the money for the construction of these hospitals in Michigan is to come from local sources, with the federal government furnishing the remaining third. Under this program, emphasis will be placed on general hospitals; federal funds will be allocated to non-profit organizations only; no money will go to private hospitals. About thirty localities in Michigan are in the process of raising money for hospital construction under this Act at the present time. The passage of Michigan's Act 299 of the Public Acts of 1947, as amended, implementing the Federal Hospital Construction Act, will aid this Committee in its work of encouraging doctors to locate in rural areas by furnishing them adequate facilities with which to practice.

4. *Michigan Health Council—Community Health Councils.*—The Committee recommended the reactivation of the Michigan Health Council with donations totaling $20,000 requested for its operation from the Michigan State Medical Society, Michigan Medical Service, Michigan Hospital Service, and such other groups approved by the Board of Michigan Health Council. In order to make this a continuous full-time program the Committee also recommended the employing of a full-time field representative to carry out the purposes of the Miehigan Health Council. These purposes and projects include (a) the establishment of Community Health Councils, (b) supporting and implementing the Community Enrollment Plan of the Blue Cross in Michigan, (c) active aid, assistance and leadership in setting up district Rural Health Conferences, (d) that the Michigan Health Council carry out its activities with the approval of the county medical societies and the co-operation of the Woman's Auxiliary.

Respectfully submitted,

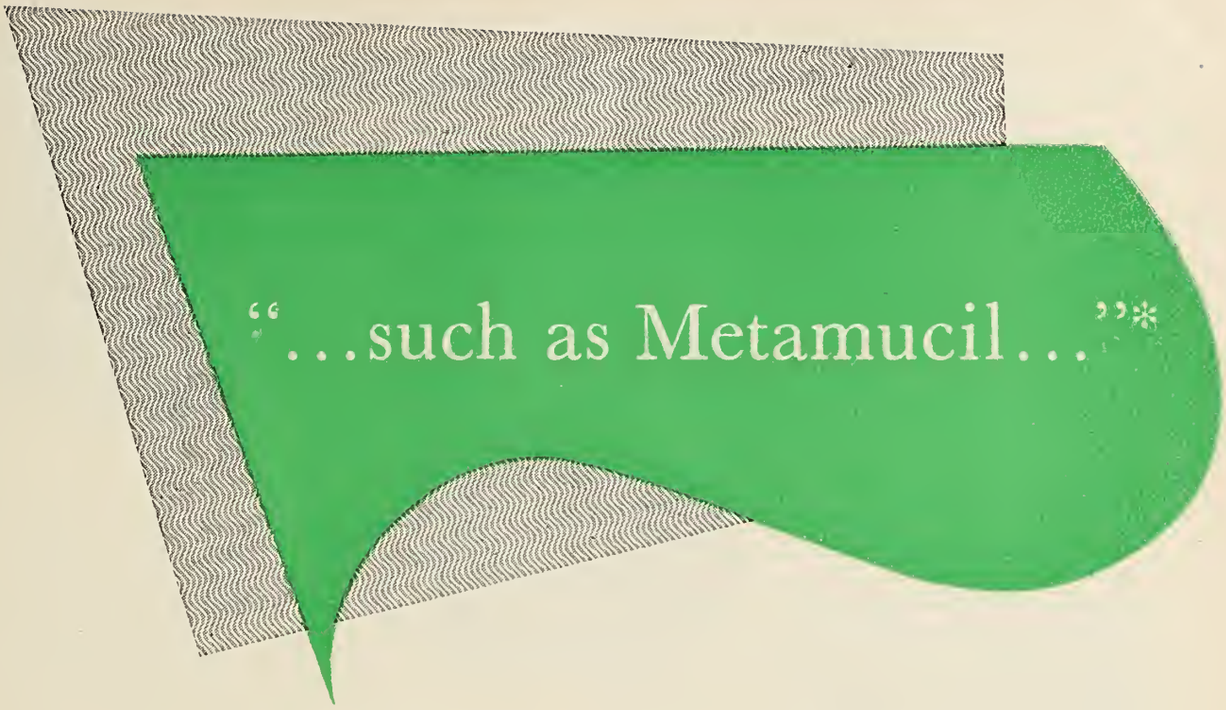
H. B. Zemmer, M.D., *Chairman*
W. H. Huron, M.D.
E. R. Witwer, M.D.
John Rodger, M.D.
R. J. Hubbel, M.D.
J. S. DeTar, M.D. *(Health Survey Advisory)*

ANNUAL REPORT OF LEGISLATIVE COMMITTEE 1947-48

The Sixty-fourth Michigan Legislature convened in special session on March 16, 1948, and adjourned on April 28, 1948. During this emergency session, no proposed legislation was enacted into law that would have lowered Medicine's high medical standards or would have been detrimental to the health and welfare of Michigan.

One act was passed which made acceptable to the Federal government the Michigan Hospital Survey and Construction Act enacted at the regular session of 1947. It consisted of an amendment to Act 299 of the Public Acts of 1947 making it possible for the Act to be enforced by designating suitable authority. At the insistance of the Michigan State Medical Society an amendment was included in the Act which provides against any attempt to use the provisions of the law to socialize medicine.

(Continued on Page 925)



For the treatment of the spastic colon the author suggests diet, elimination of the nervous element and "bulk producers." As examples of these he lists "agar-agar, in finely powdered form, in flakes, or in cereal-like form; derivatives of psyllium seed, such as Metamucil . . . ."*

METAMUCIL

"SMOOTHAGE" IN CONSTIPATION

—"encourages elimination by the formation of a soft, plastic, water-retaining gelatinous residue in the lower bowel."†

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Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

*Glafke, W. H.: Spastic Colon, M. Clin. North America 26:805 (May) 1942.

†Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1947, Philadelphia, J. P. Lippincott Company, 1947, p. 320.

University of Michigan

Postgraduate Courses

CLINICAL EXERCISES FOR PRACTITIONERS

Wednesdays, October 20, 1948 to May 4, 1949

10:00 A.M.—12:00 NOON—Attendance at surgical ward rounds and surgical operations.
1:30 P.M.— 5:00 P.M.—Surgical exercises arranged especially for practitioners. These will include clinics, lectures, and demonstration in General Surgery and all of the surgical specialities.
7:45 P.M.— 9:00 P.M.—Surgical staff conference in clinical ampitheatre.
The fee is $50. Registration: Room 2040, University Hospital

CLINICAL INTERNAL MEDICINE

Thursdays, September 30 to December 16, 1948; January 6 to April 21, 1949. 1:30 P.M.

Arrangements have been made to meet the demands of practicing physicians for further training in internal medicine by offering a clinical teaching program every Thursday afternoon, beginning September 30 and continuing through December 16, 1948. The schedule will be resumed on January 6, 1949, and continued through April 21, 1949. Patients will be presented on ward rounds conducted by two members of the senior staff of the Department of Internal Medicine. The period will end with a conference of the entire medical staff and a review of recent interesting electrocardiograms.

The fee is $50.00. Limited to 50 members. Registration: Room 2040, University Hospital.

PEDIATRICS

University Hospital—October 27-30, 1948

This postgraduate course in pediatrics is arranged for physicians who are especially interested in the field of pediatrics and communicable diseases. It includes a few lectures pertinent to special problems in pediatrics, but primarily it will consist of case presentations with discussions as to diagnosis and management of the special problems presented.

The faculty will include Doctor James L. Wilson and staff, and guest lecturers.

The fee is $25.00. Registration: Room 2040, University Hospital.

THE MICHIGAN POSTGRADUATE PROGRAM FOR GRADUATES IN MEDICINE

Autumn, 1948

The Michigan State Medical Society, in co-operation with the University of Michigan Medical School, Wayne University College of Medicine, and the Michigan Department of Health, announces the *extramural postgraduate courses* for the autumn, 1948.

Centers	*Dates*
Ann Arbor	October 14 and November 11
Bay City	October 13 and November 10
Battle Creek	October 19 and November 9
Flint	October 12 and November 9
Grand Rapids	October 19 and November 16
Jackson	October 19 and November 16
Lansing	October 26 and November 23
Mt. Clemens	October 6 and November 3
Saginaw	October 26 and November 23
Traverse City	October 7 and November 4
Upper Peninsula:	
Sault Ste. Marie	November 8
Marquette	November 9
Calumet	November 10
Ironwood	November 11
Iron Mountain	November 12

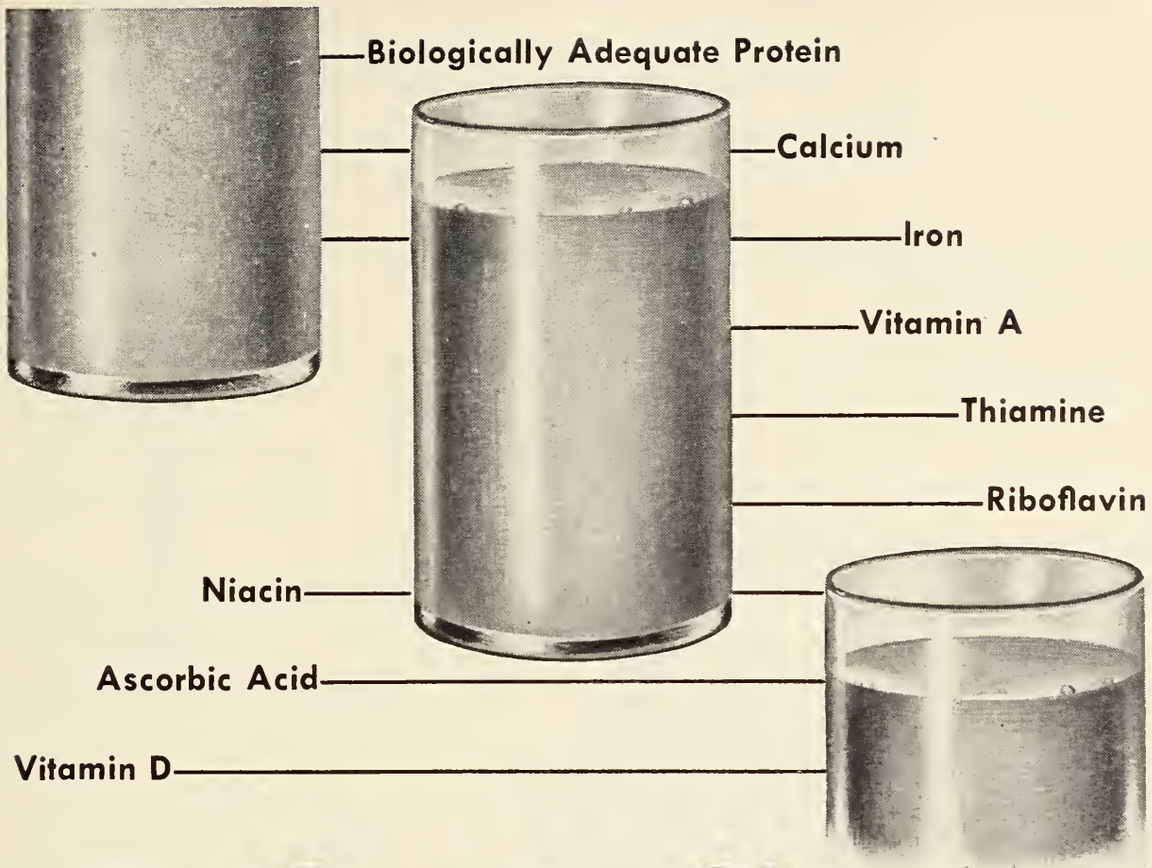
Subjects

First Day: Medical and Obstetrical Conference.
Cardiovascular renal disease and diabetes complicating pregnancy.

Second Day: Newer use of antibiotics from the Medical and Surgical Standpoint.

* * *

For further information, write H. H. Cummings, M.D., Chairman, Department of Postgraduate Medicine, 1313 East Ann Street, Ann Arbor, Michigan.



The Gamut of Nutrients

When the need for dietary supplementation arises, the delicious food drink made by mixing Ovaltine with milk finds wide application. This dietary supplement provides generously of all nutrients considered necessary, in balanced proportion for optimal utilization. Three glassfuls daily, in conjunction with even an average diet, raises the intake of essential nutrients to optimal levels.

Its appealing taste and easy digestibility virtually assure patient acceptance, as well as consumption of the recommended three glassfuls daily.

Ovaltine finds valuable use pre- and postoperatively, following recovery from infectious disease, in pregnancy and lactation, in pediatrics in the management of food-resistant children, and to supplement restricted dietaries whether prescribed or self-imposed as a result of food aversions and idiosyncrasies.

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PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

Michigan's Department of Health

G. D. Cummings, M.D., Acting Commissioner

PUBLIC HEALTH IN MICHIGAN REACHES SEVENTY-FIFTH BIRTHDAY

It was on July 30, 1873, that six members of the newly created Michigan State Board of Health met to organize and draw up a plan of work.

This meeting meant a "well done" to the efforts of a small group of foresighted men. One of these, Dr. I. H. Bartholomew, had been active in obtaining a board of health as early as 1870 when he was president of the Michigan State Medical Society. In 1873 he became a member of the Legislature for the specific purpose of establishing a public health agency.

Another name inseparably connected with the beginnings of public health in Michigan is that of Dr. Henry Brooks Baker. Chosen secretary of the Board of Health at its organization meeting, Dr. Baker served in that capacity for the first thirty formative and eventful years of its existence.

Michigan was one of the pioneers in public health. Only four other states had counterparts of the board of health that was organized in Lansing seventy-five years ago. Massachusetts was first in 1869, California followed in 1870 and Virginia and Minnesota established their public health agencies in 1872.

From 1873 until 1919, Michigan's administration of public health, with all of its implications, was vested in the Board of Health. These were significant years. Louis Pasteur was at work in his Paris laboratory on the process of fermentation, diseases of silkworms, anthrax, chicken cholera and preventive vaccination. Robert Koch, working in Germany, identified the anthrax bacillus and described the bacteria of six different kinds of surgical infection. In 1882 he discovered the tubercle bacillus and in 1883 the organism causing cholera.

Some of the problems of the Board of Health during those early years are implied in the "list of diseases dangerous to the public health." Among the diseases were: measles, whooping cough, scarlet fever, typhoid fever, smallpox and cholera, placed on the list in 1873; diphtheria, in 1875; puerperal fever and erysipelas, in 1878; typhus fever, in 1879; consumption, in 1893; yellow fever, glanders, rabies, tetanus, pneumonia, influenza and cerebro-spinal meningitis, in 1895.

A new era in public health in Michigan was ushered in at the time of the first World War. Governor Sleeper appointed Dr. Richard M. Olin as secretary of the State Board of Health in 1917, and in 1919, the Michigan State Board of Health was abolished. Its powers and duties were vested in a State Commissioner of Health assisted by a State Council of Health, an advisory group of five members. Dr. Olin was Michigan's first State Commissioner of Health. For ten years he gave to the Michigan Department of Health the leadership that placed it in the front rank of state health agencies throughout the country.

One of the significant years in public health history in Michigan came shortly after the reorganization. In 1921, the Michigan Legislature provided for the free distribution by the state of biologic products for the prevention and treatment of disease. This was the impetus for the rapid growth of the Department's laboratories. Under the direction of Dr. C. C. Young, they became world famous.

The history of public health in the state includes another significant year—1927. At that time the Legislature gave authority to county boards of supervisors to establish county or district health departments. Thus began the development of Michigan's local health organization which today is the envy of many states. Ninety-two per cent of the people of Michigan now have the services of local health departments. Seventy-one of the eighty-three countries are organized.

As Michigan today looks back on seventy-five years of public health, the words of a charter member of the Board of Health come into focus once again. "We are indeed a small band to man so long a line; and we must call to our assistance by free and cordial correspondence all physicians and all persons throughout the state who are interested in the principles of hygiene."

PASTEURIZATION LAW HAS LOOPHOLES

On July 1, Michigan became the first state in the union to have a state-wide pasteurization law, but the law has loopholes. Several Michigan communities—namely, the cities of Manistique, Ypsilanti, the village of DeWitt and several other small communities, have voted themselves out from under the provisions of the law. The law provides that all milk and milk products produced in the state shall be pasteurized, except milk sold at the farm where it is produced, but a referendum vote of residents of a community can remove that community from the protection of the law.

KILL SNAILS TO THWART ITCH

To protect vacationists at Michigan's lakes from swimmers' itch, the Michigan Stream Control Commission is conducting its snail eradication program for the ninth consecutive year.

Two field parties for investigation of complaints, beach treatment services using Commission-owned equipment, and post treatment check-ups are financed by a $10,000 grant made by the Legislature in special session. The work is done on a request basis, with the local beach owner or community providing chemicals for the treatment, and boats from which to distribute the chemical.

(Continued on Page 920)

for those **sensitive** to the proteins in milk . . .







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• MULL-SOY is a biologically complete vegetable source of all essential amino acids. In standard 1:1 dilution, it also provides the other important nutritional factors of fat, carbohydrate and minerals in quantities that closely approximate those of cow's milk.

• To prepare MULL-SOY, simply dilute with equal parts of water.

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Vitamin A from Vifort is better absorbed and utilized than vitamin A from fish liver oil. Clinical superiority has been evidenced in normal children and in patients with impaired absorption.

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water-dispersible

polyvitamin drops

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(Continued from Page 918)

Sixteen counties in the state have beaches which are infected with the itch and which require treatment. They are Jackson, Emmet, Charlevoix, Cheboygan, Leelanau, Grand Traverse, Antrim, Schoolcraft, Lapeer, Oakland, Washtenaw, Cass, Chippewa, Wexford, Roscommon and Clare.

Requests for the service should be made to the Conservation Equipment Station, Boyne City.

The Parks Division of the State Department of Conservation, this year for the first time, has organized its own party for the treatment of beaches in state parks.

POLLEN SURVEY AIDS HAY FEVER SUFFERERS

More than half of the state of Michigan may offer relief to victims of hay fever, it is indicated in the new 1947 report of the Ragweed Pollen Survey of the Michigan Department of Health. A 1948 survey is being made this summer.

The upper third of the Lower Peninsula and all the Upper Peninsula were comparatively free of ragweed pollen in the 1947 season despite the fact that favorable weed-growing conditions resulted in greater concentration of pollen than has occurred in any of the seven years that the pollen survey has been conducted.

Five areas of the state were practically free of pollen; that is, they had total seasonal pollen counts of 1,000 or less. They are: St. Ignace, Sault Ste. Marie, Cheboygan, Charlevoix and Rogers City. Eight others, with seasonal counts of less than 1,500 were comparatively free. They were: Houghton, Mackinac Island, Petoskey, Alpena, Isle Royale, Manistique, Traverse City and Munising. Other areas with seasonal counts under 2,000 were Grayling, Baldwin, Marquette, Mackinaw City and Gaylord.

Areas in the state with greatest total pollen counts were Hillsdale, with a total seasonal count of 32,383; South Haven, 26,866; Benton Harbor, 22,334; Coldwater, 22,070; Lansing, 20,932; Grand Rapids, 20,198; Jackson 19,662; Grand Haven, 15,507; Detroit, 14,702; Saginaw, 13,869; Bay City, 12,731.

Jackson and Lansing had the longest ragweed hay fever seasons, with significant counts on thirty-two days. Others with long seasons were Grand Rapids, Hillsdale and Flint with thirty-one days; Saginaw, twenty-nine days; Benton Harbor, Detroit and Grand Haven, twenty-eight days; Coldwater, twenty-seven days; and Bay City, twenty-two days.

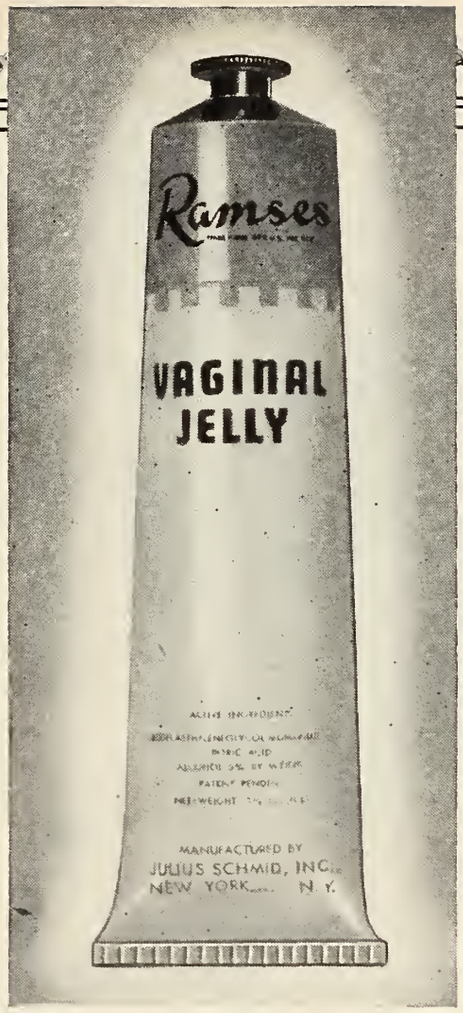
Ragweed began to pollinate the last week of July and by mid-August pollen in some quantity had appeared in every section of the state. It never reached significant quantity in Sault Ste. Marie, and did not reach significant quantity in St. Ignace, Charlevoix, Rogers City and Baldwin until September.

It should be remembered that the absolute pollen frequency in the air differs widely at a given moment in different parts of a city or county; it fluctuates greatly from hour to hour and from day to day. It is also modified by local concentration of ragweed growth, by winds which carry the pollen many miles, by lakes into which the pollen is dropped, by rain which dampens

(Continued on Page 922)

Say you saw it in the Journal of the Michigan State Medical Society

NO BETTER PRODUCT AVAILABLE



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Laboratory studies on sperm-immobilizing power and clinical studies on occlusive action and safety establish that "RAMSES"* Vaginal Jelly affords the optimum protection that a jelly alone can provide. For example.

- It will immobilize sperm in the fastest time recognizable under the Brown and Gamble method.
- It will occlude the cervix for as long as 10 hours after coitus.
- It will not liquefy or run at body temperature.
- It does not separate.
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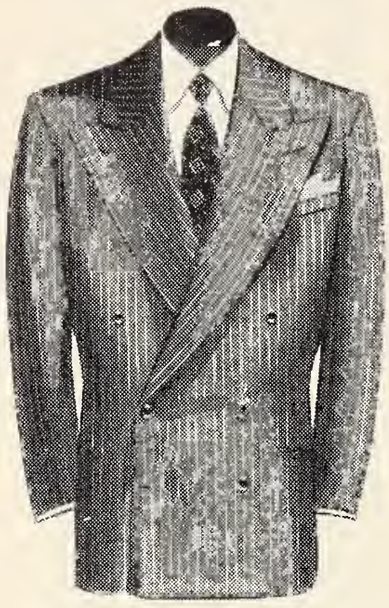
For optimum protection when dependence must be placed on jelly alone, specify "RAMSES" Vaginal Jelly.

Active Ingredients: Dodecaethyleneglycol Monolaurate 5%; Boric Acid 1%; Alcohol 5%.

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MEN'S WEAR • 617 WOODWARD

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(Continued from Page 920)

down the pollen, and by many other environmental conditions. The location of the collection station also has an effect on the count.

Many flowers, trees and weeds in Michigan produce pollen which can cause hay fever in some individuals. However, it is estimated that 95 per cent of all hay fever in the state is caused by ragweed pollen.

The 1948 Ragweed Pollen Survey got under way in fifty-two stations in the state, July 15. It will continue until killing frost. Local hospitals and laboratories are aiding local health departments to furnish day-by-day reports on incidence of pollen in their areas.

New stations this year are: Bay City (North Shore), Boyne City, Eloise, Fremont, Hart, Hastings, Holland, Kalamazoo, Midland, Mt. Clemens, Owosso, and Pinconning.

Other stations will be located in Alpena, Battle Creek, Bay City, Cadillac, Charlevoix, Cheboygan, Crystall Falls, Eagle Harbor, Escanaba, Frankfort, Gaylord, Gladwin, Grand Haven, Grand Rapids, Grayling, Harbor Beach, Hillsdale, Houghton, Ironwood, Jackson, Lansing, Ludington, Mackinac Island, Mackinaw City, Manistee, Manistique, Marquette, Menominee, Mt. Pleasant, Munising, Muskegon, Newberry, Ontonagon, Petoskey, Port Huron, Powers, Saginaw, St. Ignace, Sault Ste. Marie, South Haven and Traverse City.

FORMER MICHIGAN LABORATORY DIRECTOR

A stone inscription, "C. C. Young Public Health Laboratory," has been placed over the entrance of the diagnostic control laboratory of the Michigan Department of Health. The inscription, authorized by the State Legislature, honors the late Doctor Young, former director of the Laboratories of the Department.

POPULATION INCREASES

The new population figure for Michigan is 6,249,000. The 1940 census figure was 5,200,000.

RESORT INSPECTORS EMPLOYED

To assist with the summer resort sanitation program in the state, ten resort inspectors were added to the staff of the Department in mid-June. Most of their work is being done in counties where there are no health departments and in areas where there is a heavy resort load or where there is no sanitarian.

ADDED INFORMATION ON BIRTHS

A new item, weight at birth, has been added to Michigan birth certificates.

NEW BABY PAMPHLET

"Will You Nurse Your Baby?" a new illustrated pamphlet on the importance and technique of nursing the baby, written by Alexander Campbell, M.D., has been publishd by the Department and is available without charge from local heath departments or the Michigan Department of Health.

Say you saw it in the Journal of the Michigan State Medical Society

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*June, 1948*	*June, 1947*
Diphtheria	7	29
Gonorrhea	887	758
Lobar pneumonia	85	73
Measles	6,665	795
Meningococcic meningitis	12	6
Pertussis	135	807
Poliomyelitis	5	1
Scarlet fever	549	433
Syphilis	1,143	1,189
Tuberculosis	552	696
Typhoid fever	8	9
Undulant fever	13	32
Smallpox	0	1

In Lansing

HOTEL OLDS

Fireproof

400 ROOMS

Communication

Wilfrid Haughey, M.D.
Editor Michigan State Medical Journal
Battle Creek, Michigan

Dear Sir:

The world is clamoring for new ideas for cancer prevention and cure, so you are justified in publishing such bizarre papers as Harold S. Hulbert's "A Cancer Cemetery." Having done so, you must expect a flood of protests, so I am joining the rising tide.

The author gives as a basis for his rather gruesome experiment the analogies of penicillin and phage, substances that attack living organisms. Yet his project would be an attempt to train some sort of animalcule to attack dead cancers. Of course, nature is rife with creatures that will consume dead cancers, so before we start excavating for those 40-foot walls, let us distinguish between the physiology and chemistry of live and dead tissue.

By the way, just what are cemetery worms?

Very truly yours,
PAUL W. KNISKERN, M.D.

Grand Rapids, Michigan
June 30, 1948

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SURGICAL CORSETS
SPINAL BRACES
ARTIFICIAL LIMBS
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SABEL'S CLUB FOOT SHOE
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RIGHT LEFT

Dotted line on cut shows outline of normal shoe. Shoe cut shows abnormal outward swing of Sabel's Club Foot Shoe.

Sabel's Club Foot Shoes are for use after the doctor has over-corrected the position of the club foot. The outward swing of this shoe braced by the long outside counter will tend to keep the position the doctor desires.

Sabel's Surgical Shoes are carried in pattern and leather matching the Club Foot Shoes so that where required, even in split sizes, they can be fitted to the other foot.

The Sabel Line, includes, in addition to the Club Foot, the Pre-walker, Brace, Pigeontoe and Surgical Shoes

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Stuart J. Rackham **President**

Clyde K. Taylor **Manager**

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In Memoriam

WALTER DEN BLEYKER, M.D., Kalamazoo, Michigan, was born October 29, 1876, in Kalamazoo, Michigan, and graduated from the University of Michigan Medical School in 1900. Dr. Den Bleyker was superintendent of the Fairmount Hospital from 1918 to 1924 and in 1906 started the first Tuberculosis camp in Kalamazoo. He was a past president of the Kalamazoo Academy of Medicine, a member of the Michigan State Medical Society and the American Medical Association. Dr. Den Bleyker died on June 29, 1948, in Kalamazoo, Michigan, at the age of seventy-one years.

* * *

HENRY GRAY GLOVER, M.D., Jackson, Michigan, was born August 20, 1860, in Alton, Illinois, and graduated from the Hahnemann Medical College and Hospital, Chicago, Illinois, in 1882. Dr. Glover was twice president of the Michigan Homeopathic Society, was a retired member of the Jackson County Medical Society, the Michigan State Medical Society and the American Medical Association. He died on June 21, 1948, at the age of eigthy-seven years, at the home of his son in Detroit, Michigan, where he had been living for the past year following the death of his wife.

* * *

LESTER FLOYD KENNEDY, Detroit, Michigan, was born in 1892 and graduated from the Wayne University College of Medicine in Detroit, in 1915. Dr. Kennedy was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association. He died on June 28, 1948, in Detroit, Michigan, at the age of fifty-six years.

* * *

MALCOLM McPHAIL, Great Falls, Montana, was born in 1868. He was graduated from the University of Toronto Faculty of Medicine in 1895, when he began practice in Manilla, Ontario, Canada. He came to the United States in 1914 and was in practice for twenty-eight years in Detroit, Michigan. In 1942, Dr. McPhail moved to Great Falls, Montana, where his son, Dr. Francis L. McPhail, is in practice. He was a former member of the Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. McPhail passed on, on June 12, 1948, in Great Falls, Montana, at the age of eighty years.

* * *

THOMAS L. PEACOCK, Lake Odessa, Michigan, was born in 1869 and graduated from the Michigan College of Medicine and Surgery, Detroit, Michigan, in 1899. He was a former member of the Ingham and the Ionia-Montcalm County Medical Societies, the American Medical Association, the Michigan State Medical Society and the Physical Medicine Association of Chicago. He practiced medicine for thirty-eight years in Sunfield and Lansing, prior to retiring and moving

Say you saw it in the Journal of the Michigan State Medical Society

to Lake Odessa. Dr. Peacock had been ill for some time and died on May 27, 1948, in Lake Odessa, Michigan, at the age of seventy-nine.

* * *

MARIANNA EDDY SMALLEY, M.D., Ann Arbor, Michigan. Born in 1903 and graduated from the University of Michigan Medical School in 1931. Dr. Smalley conducted the Washtenaw County Tuberculosis Clinic for nine years and had been a Medical Instructor at the University of Michigan since 1934. She was a member of the Michigan Trudeau Society, the National Trudeau Society, the American History of Medicine Society, the Washtenaw County Medical Society, American Medical Association and the Michigan State Medical Society. Dr. Smalley died on June 21, 1948, in Ann Arbor, Michigan, at the age of forty-five years.

The Michigan Rehabilitation Association will hold a Conference at the Park Place Hotel, Traverse City, September 19-20-21. All members of the Michigan State Medical Society are cordially invited to attend, especially the meeting of the Scientific Section, Monday morning, September 20.

ANNUAL REPORT OF LEGISLATIVE COMMITTEE, 1947-1948

(Continued from Page 914)

The Legislative Committee met on December 4 and developed plans for better contact between legislators and doctors. It advised the development and furtherance of a pre-school immunization program and the sponsoring of an annual "Immunization Month" throughout the state. The Basic Science Law was reviewed and progress noted in efforts to improve its administration. Consideration was given the changes in rules and regulations of the Michigan Board of Registration in Medicine pertaining to two-three-four-year resident postgraduate students.

The Legislative Committee again expresses appreciation to the intelligent and health-minded members of the Michigan Legislature for their courteous consideration of the legislative problems of the medical profession and the courteous reception they extended to our representatives.

Respectfully submitted,

L. A. Drolett, M.D., *Chairman*
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W. A. Chipman, M.D.
T. S. Conover, M.D.
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Changes in Uniform Fee Schedule for Governmental Agencies.— Item 0313—from $5 to $10; Item 0217—$50; $100; A.A.; Item 9215—from $25 to $35; New Item 9999—Services not otherwise classified.

* * *

All denominational hospitals, totalling some 400, have been excluded from government control under the new British National Health Act, which goes into effect July 5, according to Morris Fishbein, M.D., Editor JAMA.

* * *

Joseph Merante, portrait photographer, who has been commissioned to obtain a photograph of every MSMS member for the State Society archives, is now photographing Wayne County physicians at the various hospitals in Detroit.

* * *

William Dozier, Public Relations Counsel for the Medical Association of the State of Alabama, visited the MSMS Public Relations department in Lansing on July 19 for a study of Michigan's activities in medical public relations.

* * *

"Are you enrolled in Blue Cross—Michigan Medical Service-Michigan Hospital Service?" Ask every patient you admit to a hospital this question. This will aid you in arrangements for special services, not covered by Blue Cross-Blue Shield.

* * *

J. Earl McIntyre, M.D., Lansing, Secretary, Michigan State Board of Registration in Medicine, and member of the National Board of Medical Examiners of the United States, was re-elected to a six-year term on the National Board at its May 22 meeting in Philadelphia.

* * *

Sidney Friedlaender, M.D., and Alex S. Friedlaender, American Journal of Medicine, June, 1948; also of "An *M.D.*, Detroit, are authors of an original article "Paternal Benadryl in Allergy" which appeared in the Evaluation of Antistine, a New Antihistaminic Substance," which was published in *Annals of Allergy,* February, 1948.

* * *

"Post-Encephalitic Parkinsonism" is the title of a new two-reel 16 mm., black and white, silent film which describes the pathology, signs and symptoms and modern therapy of this disease. This 25-minute film is available to county societies and other medical groups through Lederle Laboratories Division, 30 Rockefeller Plaza, New York 20.

* * *

Burt R. Shurly, M.D., Detroit, attended his last session as a Delegate of the AMA House of Delegates, at the recent Chicago meeting. Dr. Shurly has attended twenty-eight consecutive sessions. He was the second oldest Delegate in the House, in point of service. He said that in all the years of his service as a Delegate, the fight against socialized medicine was the most interesting, from his viewpoint.

* * *

Selective Service—Osteopaths.—The Senate, when debating the Selective Service Draft Bill, was offered an amendment by Senator Morse that osteopaths be named with doctors of medicine and dentists. The amendment did not receive much debate and was rejected by a standing vote.

* * *

Whither Medicine by Nell Ward, M.D., which appeared in the *Bulletin of the Genesee County Medical Society* of May 7, 1948, outlines recent plans and activities for the socialization of medicine throughout the world, under the aegis of the International Labor organization. Well worth reading.

* * *

"The Use of Digitalis in Heart Failure" is a new film prepared by the Department of Pharmacology, Cornell University Medical College, which describes recent clinical and laboratory investigations in the use of various types of digitalis. This is a 16 mm. sound and color, 1200 feet and runs thirty-five minutes. The film is available for county and special medical societies and may be secured from the Wyeth Incorporated Film Library, 1600 Arch St., Philadelphia, 3, Pa.

* * *

The American College of Physicians will conduct its 30th Annual Session at the Waldorf Astoria, New York, March 28 to April 1, 1949.

ACP also announces that a limited number of Fellowships in Medicine will be available from July 1, 1949 to June 30, 1950. The stipend will be from $2,200 to $3,200. Applications will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate no later than November 1, 1948.

* * *

The University of Michigan reports that the State needs 4,800 teachers. The teaching profession does not appear to be attractive to the rising generation.

Proponents of socialized medicine often point to education as an example of a successful governmental function. Force State Medicine on the nation, and soon the University of Michigan would report that, though thousands upon thousands of additional physicians are needed, the profession of medicine (under compulsory auspices) is not attractive to the youth of the nation.

(Continued on Page 928)

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(Continued from Page 926)

Have you read "Is Medical Care Expensive?" This talk by Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the AMA, is worthy of your perusal. It presents a convincing argument that, although the American people have been paying out more dollars for medical care in recent years, the percentage of the national income and total consumer expenditures spent for medical care have been decreasing —and this despite the advances in medical science which have contributed to making medical care more expensive. For copies, write American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.

* * *

Wm. J. Stapleton, Jr., M.D., Detroit, received the degree of Doctor of Arts in Medical Education from Wayne University at its commencement exercises of June 17. Active in the medical profession since graduation from Michigan College of Medicine in 1900, Dr. Stapleton served on Wayne's College of Medicine staff from 1902 until his retirement last June. In 1914 he was appointed Professor of Medical Jurisprudence and since his retirement has been named an Emeritus Professor in this field. He served as Acting Dean on two occasions during the last ten years. Dr. Stapleton is a past president of the Wayne County Medical Society. Congratulations, Dr. Stapleton!

* * *

The Muskegon County Medical Society Bulletin featured in its May, 1948, number a "guest editorial" by Ralph Eggert of the *Muskegon Chronicle.* Among quotable items in Mr. Eggert's editorial are:

"A doctor is a misunderstood person. . . . Mr. John Q. Public highly prizes medical service as an economic good, but finds it is too scarce. . . . Why are doctors so few? Why don't the medical colleges send them out faster? Since most ailments are relatively simple—why do all doctors have to spend so many years in training? Why don't doctors give more pills—like they used to years ago, when they asked you to stick out your tongue and say 'ah'? It's time to get better acquainted with the doctors."

* * *

Presentation of Special Memberships.—Recommendations for Special Membership are to be presented to the Chairman of the Committee on Special Memberships of the MSMS House of Delegates prior to the first meeting of the House, for presentation *in toto* by the committee chairman to the House, according to the procedure set up by the 1946 House of Delegates.

The first meeting of the 1948 House of Delegates will be held Monday, September 20, 1948, at 10:00 a.m. in the English Room of the Book-Cadillac Hotel, Detroit.

The Secretary of the House of Delegates, L. Fernald Foster, M.D., will collect the resolutions and recommendations for Special Memberships and transmit them to the Committee on Special Memberships, of which J. J. Lightbody, M.D., Detroit, is chairman.

* * *

International College of Surgeons.—The Thirteenth Assembly and Convocation of the United States Chapter,

(Continued on Page 930)

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(Continued from Page 928)

International College of Surgeons will be held at the Kiel Auditorium in St. Louis, Missouri, Monday through Saturday, November 15, 16, 17, 18, 19, and 20, 1948.

An outstanding program—a copy of which will be sent on request to the college, 4952 Maryland Avenue, St. Louis, Missouri, will feature surgical clinics on Monday and Saturday and national and international lecturers on Tuesday, Wednesday, Thursday and Friday.

We are assured of sufficient hotel accommodations to comfortably house all our registrants. For reservations write to Willard Bartlett, Jr., M.D., Chairman Housing Committee, 919 Syndicate Trust Building, St. Louis 1, Missouri.

* * *

The Upper Peninsula Medical Society's 1948 meeting, held at the 500 Bushel Club, Marenisco, Michigan, attracted 178 doctors of medicine. Michigan guest essayists included L. Fernald Foster, M.D., Bay City, MSMS Secretary; A. C. Furstenberg, M.D., Ann Arbor; L. J. Gariepy, M.D., Detroit, and A. D. Ruedeman, M.D., Detroit.

D. C. Eisele, M.D., Ironwood, president of the Society, welcomed the guests and introduced the 1949 president, R. T. Montgomery, M.D. of Sault Ste. Marie, and the president-elect, Alfred LaBine, M.D. of *Houghton*. State Senator Joseph P. Cloon of Wakefield was toastmaster at the U.P.M.S. annual banquet of June 26.

Next year's meeting will be held at Blaney Park in June.

* * *

Dr. Perrin H. Long's medical advisory committee to Office of Civil Defense Planning completed its job on July 10, turning in a master plan for utilization of physicians, dentists, nurses, and allied professionals in event of a sudden attack. Dr. Long is at Johns Hopkins, Baltimore. Also AMA President R. L. Sensenich had several conferences in Washington, D. C., the week of July 12 with military medical heads and the Hawley Board, the subject being the services' acute problem in obtaining the doctors they need, which is nearing the desperation stage. It is understood that the Army called into Washington, in July, all field army surgeons and air force command surgeons to discuss medical-dental manpower conservation and retrenchment, as well as additional inducements for recruitment.

* * *

Scholarships Not Allowed by Congress.—The supplementary appropriation for the Federal Security Administration was amended in the Senate by the addition of a clause providing that $132,000 of the total $13 million appropriated originally might be diverted to payment of twenty-five four-year scholarships in medical schools for persons who would be willing to practice in areas where there might be an acute shortage of physi-

(Continued on Page 932)



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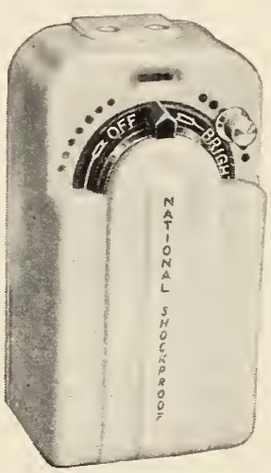


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(Continued from Page 930)

cians, as in rural areas of the south, southwest, et cetera. The scholarships were to amount to $1,320 a year to cover tuition, books, and subsistence. When the bill went to conference, the House conferees objected to the amendment and it was defeated.

This eliminated the opening wedge for federal subsidization of medical education.

* * *

Blue Shield Enrollment.—Enrollment in non-profit prepayment plans for medical care passed the 8,000,000 mark during the second quarter of 1948. The Blue Shield enrollment report for March 31, 1948, covering all non-profit plans in the nation with medical or Blue Cross sponsorship revealed a first quarter total of 7,928,128 members.

Although all non-profit plans were included in the tally, some of the reporting organizations are not known as Blue Shield Plans, or affiliated with Associated Medical Care Plans. Blue Shield Plans recorded a total membership of 6,473,439 persons, approximately 80 per cent of the grand total.

Total membership gain during the first quarter of 1948 was 645,222 persons, representing a 9.19 per cent increase over December 31, 1947.

Michigan Medical Service continues to be the largest Blue Shield Plan in the United States with a total enrollment of 1,034,000.

* * *

Mississippi Valley Medical Society.—The Thirteenth Annual Meeting, Mississippi Valley Medical Society, will be held at the Abraham Lincoln Hotel, Springfield, Illinois, September 29, 30, and October 1, 1948, under the presidency of Dr. Willard O. Thompson, Professor of Medicine, University of Illinois College of Medicine. Over twenty-five clinical teachers from the leading medical schools will conduct this great postgraduate assembly, whose entire program is planned to appeal to general practitioners. There will be some forty scientific and technical exhibits, noon round-table luncheons, clinicopathologic conference, big banquet preceded by a social hour, et cetera. NO REGISTRATION FEE will be charged and every ethical physician is cordially invited and urged to attend. The entire program and all exhibits will be held in the Abraham Lincoln Hotel. A detailed program may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Ill.

* * *

AMA registration at the 1948 Chicago annual session was 11,963 Fellows. Doctors' wives and guests, exhibitors and members of their families, and others swelled the attendance another 10,000 for a total of 22,000.

R. L. Sensenich, M.D., South Bend, assumed the presidency of the AMA.

Ernest E. Irons, M.D., Chicago, was chosen as President-Elect and will take office in Atlantic City in June, 1949.

R. W. Fouts, M.D., of Omaha was selected as Vice

(Continued on Page 934)



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(Continued from Page 932)

President, George F. Lull, M.D., Chicago, as Secretary and Josiah J. Moore, M.D., Chicago, as Treasurer.

Francis F. Borzell, M.D., Philadelphia, was elected Speaker of the House of Delegates and James R. Reuling, M.D., Bayside, N. Y., as Vice Speaker.

New Trustees are Gunnar Gundersen, M.D., La Crosse, Wisc., Edward S. Hamilton, M.D., Kankakee, Ill., and Walter B. Martin, M.D., Norfolk, Virginia.

Atlantic City will be host the week of June 6, 1949; San Francisco will house the Session in 1950, and Atlantic City will again have the convention in 1951.

* * *

The Fourth Annual Conference of Presidents and Other Officers of State Medical Associations was held Sunday, June 20, 1948, at the Sheraton Hotel, Chicago. This is the organization growing out of the conference called by A. S. Brunk, M.D., Detroit, while president of the Michigan State Medical Society, to formulate a positive plan, endorsed by the medical profession, which would give the public a needed program for extension of medical services to all who need them, in the American manner. The first meeting was held at the Sheraton, Chicago, in December, 1945, the second in San Francisco, July, 1946, and the third in Atlantic City on June 8, 1947.

The 1948 program was as follows:

"Despotism by Consent of the Governed" by Joseph H. Howard, M.D., Bridgeport, Connecticut, President Elect, Conference of Presidents.

"The Blue Shield—Blue Cross Program" by Paul R. Hawley, M.D., Executive Director Blue Shield-Blue Cross; Major General USA (Retired); Former Chief Medical Director, Veterans' Administration.

"Why a State Medical Association?" by John W. Cline, M.D., San Francisco, immediate Past President, California Medical Association.

Joseph H. Howard, M.D., Bridgeport, Connecticut, assumed the presidency of the Conference; E. R. McAllister, M.D., Seminole, Okla., was chosen as president-elect, and John E. Farrell, Providence, R. I., as secretary-treasurer. Dr. Brunk's term as a member of the Executive Committee continues until June, 1949.

* * *

National Service Agency Studied.—The much-discussed proposal to establish a national service agency for enrolling "national accounts" is still being studied by the Blue Shield and Blue Cross Commissions.

A "national account," which has become a serious problem for Blue Shield and Blue Cross plans throughout the nation, is defined as any firm whose employes are spread over an area served by more than one Plan.

The enrollment of these accounts has been handicapped for several years by variations among Plans in benefits offered, subscription dues, administrative regulations, and the lack of an effective national agency to conduct satisfactory negotiations.

Originally presented at the 1948 Semi-Annual Conference of Blue Shield and Blue Cross Plans in Los Angeles during April, 1948, the proposed national service agency was modified considerably by the conference and referred to the respective Commissions for revision.

A revised draft of the proposal, prepared by staff

members, was submitted to a joint meeting of the Blue Shield and Blue Cross Commissions on June 18, 1948, incorporating the modifications agreed upon at the Los Angeles conference. Still further changes were recommended by the Commissions, with the proposal referred once more to the staff members for additional revision.

When final agreement has been reached by the Blue Shield and Blue Cross Commissions, the completed proposal will be submitted to all Blue Shield and Blue Cross Plans and referred also to the AMA Council on Medical Service, as well as the proper body within the American Hospital Association.

* * *

Organization Meeting of Michigan Academy of General Practice.—Acting as host, the Wayne County Academy of General Practice plans to hold its quarterly meeting during the MSMS meeting at Detroit for the purpose of organizing the Michigan Academy of General Practice. The meeting will be conducted in the Wayne Room, Hotel Statler, on Thursday, September 23, at a time that will not interfere with the state program, 7:30 p.m. The meeting will end at 10:00 p.m., in time for the MSMS Ball.

One of the first requisites of the Academy is membership in the local and state medical society in the area in which the applicant practices.

Michigan State Medical Society is well to the fore when it comes to fighting the problems of the General Practice of Medicine. The officers, The Council, the editorial staff, the executive secretary of the MSMS and the delegates to the AMA deserve the highest praise for their co-operation.

The belief of the Special Committee on General Practice in the AMA that the general practitioner does not show adequate interest in organized medicine, local, state or national, and that he should be urged to participate in all activities of organized medicine, both scientific and organizational, does not hold true in Michigan.

It is hoped that every general practitioner in the state will be able to attend this important meeting and prove that general practitioners are interested in both their State Society and a State Academy of General Practice.

To further the best interests of the Academy, it would be much appreciated if some active general practitioner in each county or local medical society would forward a list of general practitioners in order that contacts may be made and geographical representation assured. Communication should be addressed to E. Clarkson Long, M.D., Secretary, MSMS General Practice Section, 2626 Rochester Ave., Detroit 6.

* * *

Industrial Hygiene in Wartime Planned.—Dr. Carl M. Peterson, Chicago, Secretary, and Dr. A. J. Lanza, New York, Chairman, of the Council on Industrial Health, and Drs. James C. Sargent, Milwaukee, Chairman, and Richard L. Meiling, Columbus, O., of the Council on National Emergency Medical Service, represented the American Medical Association at a meeting in Washington, July 7-8, held for the purpose of dis-

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cussing industrial health problems relating to national defense.

Drs. Peterson, Lanza, Sargent and Meiling, along with other doctors, dentists, engineers, specialists in public health and industrial hygiene, consulted for two days with representatives of the armed forces medical departments and government health agencies.

In the event of another war, the success of an industrial health program, now universally recognized as a vital factor in civil defense, would depend largely on complete co-ordination of military and civil work in this field. A vast research program to determine what personnel and supplies would be needed and just how much of these are now available must be completed before plans to meet a war emergency can be crystallized. The Washington conference further integrated the work of the various interested agencies and outlined additional research that remains to be done.

By agreement with the AMA Council on National Emergency Medical Service, the AMA Council on Industrial Health has undertaken to develop a plan to cover those phases of civil defense which affect the industrial medical profession and to confer with other related professional groups.

A consulting committee, representative of both groups, met at AMA headquarters recently and took the position that medical and health problems associated with industrial mobilization, the classification and assignment of the labor force, the available professional manpower including functions of recruitment and training, the expanding scope of industrial medical and health services as affected by new weapons, new materials and the dispersal of essential industries, deserve consideration at highest levels of planning and co-ordination.

Other meetings will be held in the near future to determine further essential steps and to integrate emergency industrial medical services into community programs.

* * *

Child Safety.—A reduction in the number of child accidents, both fatal and nonfatal, is the objective of an intensive child safety campaign to be launched this fall by the Metropolitan Life Insurance Company with the co-operation of the U. S. Children's Bureau, the American Academy of Pediatrics, and the National Safety Council. Accidents are the leading cause of death among children of more than one year of age, with death rates per 100,000 population far surpassing those of any other cause. For example, in 1946, according to the experience of the Metropolitan among its Industrial policyholders, the accident death rate among children from 1 to 4 was 48.1 per 100,000, as compared with a rate of 28.2 per 100,000 for pneumonia, the next leading cause of death. It is significant that at this age group there has been little improvement in the past fifteen years, although the death rate from disease has been cut approximately 67 per cent.

In the age group five to nine, the death rate for accidents was 25.7 per 100,000 as compared with a rate of 4.6 for rheumatic fever and organic heart disease, the next cause. In the age group ten to fourteen, the



death rate for accidents was 20.8, and that for rheumatic fever and organic heart disease, 7.2.

The present relatively low death rates from all non-accident causes, as compared with those of but a few years ago, are the result of advances in medical science and concentrated efforts in the field of child health. Efforts must now be intensified to bring about a reduction in the number of child accidents as well. The program is planned to encourage public health, medical, safety, and other organizations, as well as the general public, to give even greater attention to the child safety phase of the child health program.

As part of the campaign the Metropolitan has prepared a twelve-page illustrated booklet, "Help Your Child to Safety." While the booklet is addressed to parents and stresses the importance of co-operation on the part of all members of the family regarding child safety, it also emphasizes some significant ways of combatting physical hazards and unsafe practices resulting in child injuries. The Metropolitan Field Force throughout the United States will co-operate in this campaign, as it has in so many others, by distributing the booklet and in other appropriate ways will help to make the public aware of what can be done to cut down the tremendous toll of child accidents.

Supplies of the booklet and copies of statistical charts, prepared talks, suggested press releases, and other source material will be available upon request by September 1 for use in local organized child safety programs.

DETROIT PHYSIOLOGICAL SOCIETY

(Continued from Page 886)

table have been rendered radioactive. Not all of the resulting isotopes are usable directly on living patients. Some of them have too long or too short a half-life or too weak a radioactive emanation to be suitable. The useful elements can be roughly divided into three general groups: the non-specific elements such as Sodium 24, which is a tracer for extracellular fluid; second, Radioactive Phosphorus (p^{32}), which is a tracer for growth processes in general, and, third, the specific class of tracers like Radioiodine, which detects and measures the activity of a particular type of tissue.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE HEALTHY HUNZAS. By J. I. Rodale, Editor of Organic Gardening. Emmaus, Pa.: The Rodale Press, 1948. Price $2.75.

The author believes in the processes of agriculture which he calls organic gardening. He tells the story of a race of people living in the most northern part of India, just across the border from Russia, who for some unknown reason have adopted a strictly organic form of fertilization, all organic matter returned to the land, after it has been fermented in compost piles. The health of the people is remarkable, many of the diseases of civilization being unknown. The book is challenging to our vaunted modern civilization and progress. The theories and experiences of these people would bear study. A most interesting book.

OPERATIVE GYNECOLOGY. By Harry Sturgeon Crossen, M.D., Professor Emeritus of Clinical Gynecology, Washington University School of Medicine; Consulting Gynecologist to the Barnes Hospital, St. Louis Maternity Hospital, St. Luke's Hospital, DePaul Hospital, and Jewish Hospital, and Robert James Crossen, M.D., Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine; Assistant Gynecologist and Obstetrician to the Barnes Hospital and the St. Louis Maternity Hospital; Gynecologist to St. Luke's Hospital and DePaul Hospital. Sixth edition entirely revised and reset. 1334 illustrations including thirty in color. Pages 979. St. Louis: C. V. Mosby Company, 1948. Price $15.00.

A very well-organized, complete work on operative gynecology. The authors draw from a very substantial experience in teaching and practice.

Much material that related to the history of the development of operative procedures in previous editions have been deleted to devote more space to the methods of detecting and treating cancer.

Chapters on anesthesia, the intestinal tract in relation to gynecologic surgery, and medicolegal points are included. Operative procedures are well described and illustrated.

The depth and scope of this book will guarantee its use by the student and surgeon alike.

R.L.C.

TEXTBOOK OF PATHOLOGY. By William Boyd, M.D., M.R.C.P., F.R.C.P., LL.D. Professor of Bacteriology and Pathology of the University of Toronto. 5th edition. 1049 pages. 500 illustrations and 30 colored plates. Philadelphia: Lea & Febiger, 1947; reprinted 1948. Price $10.00.

Dr. Boyd announced in the preface to the first edition of this text that the book was written for the student and graduate practitioner of medicine and not for the specialist in pathology. In the four succeeding editions he has not deviated from this principle and has also adhered in his effort to correlate his pathological descriptions with the symptomatology and physical findings associated with the disease process.

While the author and his fellow pathologists recognize that his works are not reference books, they are often quoted because of the pithy observations and pointed analogies which hold the reader's attention and stimulate his interest in a subject often too aridly presented. If faults are to be found, and they are few, it might be

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the inadequate definition of many of the illustrations, a fault somewhat redeemed by their number.

The present edition is well bolstered by recent advances in pathology; for example, the genesis and pathology of erythroblastosis is well presented despite the fact that it remains currently controversial in many respects. On the other hand, space is devoted to anachronistic disorders such as chlorosis, which at present is about as ubiquitous as the "milk sickness," to the exclusion of such items as tuberculosis endometritis. The book is warmly recommended to those for whom it was written.

A.A.H.

HUMAN PHYSIOLOGY. By F. R. Winton, M.D., D.Sc., Professor of Pharmacology, University College, London, and L. E. Bayliss, Ph.D., Reader in Physiology, University College, London. Third edition, with 248 illustrations. Philadelphia and Toronto: The Blakiston Company, 1948. Price $7.00.

This volume is the third edition of a work deserving of great attention. A thorough revision has been made of the whole book, due to the great advances in the physiology of medicine in the past few years. The textbook format is complete, but the size is not too great. We can recommend the book to the busy student who cannot wade through much research, but who wishes authoritative information.

THE BATTLE OF THE CONSCIENCE: A PSYCHIATRIC STUDY OF THE INNER WORKING OF THE CONSCIENCE. By Edmund Bergler, M.D., Washington Institute of Medicine, Washington, D. C. Price $3.75.

In this book, Dr. Bergler presents an interesting and thought-provoking study of conscience. He emphasizes particularly that portion of the conscience which is part of the inner man or of the unconscious. The study provides an explanation for many disorders in which the patient seems to be working against himself, "leading with his chin," as the saying goes. This study covers the factors involved in inner sense of guilt, the tortures suffered by the neurotic, and the experiences of those personalities characterized as "injustice collectors."

In general, one can say that the book is well written, is interesting, and easier to read than many such detailed studies. It can be recommended to those who have interest in the deeper working of the personality.

F.O.M.

NEUROANATOMY. By Fred A. Mettler, A.M., M.D., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University, New York. With 357 illustrations including 33 in color. Second edition. St. Louis: The C. V. Mosby Co., 1948. Price $10.00.

The subject of neuroanatomy has long been noted as difficult from the standpoint of the teacher as well as from the standpoint of the student. Textbooks on this subject are frequently characterized as dry, uninteresting, and difficult to read.

The second edition of Dr. Mettler's textbook reveals none of these usual defects. The book is interesting to read, the illustrations are adequate and in general are located in such a way that no great turning of pages is necessary.

The first part of the book is given to the gross aspects of the neural system and includes a number of in-

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formative and well-presented chapters on the surrounding media of the spinal cord and surrounding structures of the brain. The second part, given entirely to microscopic study of the nervous system, is well written and well organized. This section includes a list of modern references which is unusually complete and extensive.

In the opinion of this reviewer, this textbook should prove valuable to students and should also provide a good reference work for the practitioner.

F.O.M.

THE HEBREW MEDICAL JOURNAL. Volume I—1948.

The appearance of Volume I—1948 of the *Harofe Haivri,* The Hebrew Medical Journal, inaugurates the twenty-first successful year of its publication under the editorship of Moses Einhorn, M.D. The Journal's contents are not confined to technical medical topics but is divided into several sections covering a variety of related subjects of interest to the medical profession.

The original articles are summarized in English to make them available to those who are unable to read Hebrew.

SUCCESSFUL MARRIAGE, An Authoritative Guide to Problems Related to Marriage from the Beginning of Sexual Attraction to Matrimony and the Successful Rearing of a Family. Edited by Morris Fishbein, M.D., Editor, *Journal of the American Medical Association* and *Hygeia, The Health Magazine;* and Ernest W. Burgess, Ph.D., Professor and Chairman, Department of Sociology, University of Chicago. Garden City, New York: Doubleday & Co., Inc., 1947. Price $7.50.

Some very outstanding authors have contributed their opinions and advice in preparing this book. It is rather massive but full of most valuable suggestions and advice. Part I, Preparation for Marriage, deals with love, the choice of mate, courtship and engagement, premarital sex relations, the need and value of premarital physical examinations, and the marital counsellor. Part II, Marriage, stresses anatomy and physiology, technique, sex adjustment, marital adjustments, the wedding, home management and finances, extra-marital relations, psychology and factors in marital maladjustments, health and hygiene, miscarriages and abortion. Part III deals with conception, pregnancy and childbirth. Part IV is devoted to the child—his growth, psychology, education, habits, remarriages, et cetera. Then there is a part on social problems, diseases, prostitution, divorce, et cetera. All in all, this is a very comprehensive and instructive book.

PRACTICAL BACTERIOLOGY, HEMATOLOGY, AND PARASITOLOGY. By E. R. Stitt, M.D., Ph.M., Sc.D., LL.D., Rear Admiral, Medical Corps, and Surgeon General, U. S. Navy, Retired. Graduate, London School of Tropical Medicine. Formerly President of the National Board of Medical Examiners; Head of the Department of Tropical Medicine, USN Medical School; Associate Professor of Medical Zoology, University of the Philippines. Consultant in Tropical Medicine to the Secretary of War, World War II; Paul W. Clough, M.D., Physician in Charge of the Diagnostic Clinic, Johns Hopkins Hospital; Assistant Professor of Medicine, Johns Hopkins University; Associate Professor of Medicine, University of Maryland; Sars E. Branham, M.D., Ph.D., Sc.D., Senior Bacteriologist, National Institute of Health; Professorial Lecturer in Preventive Medicine, The George Washington University School of Medicine; Chairman, Laboratory Section American Public Health Association, 1946-1947, and Contributors. Tenth Edition. Philadelphia: The Blakiston Company, 1948.

The first edition of this book was prepared almost forty years ago, and was the first attempt to cover clinical microscopy in all its fields of bacteriology, helminthology,

Please Meet...

LOUIS HAUGHEY

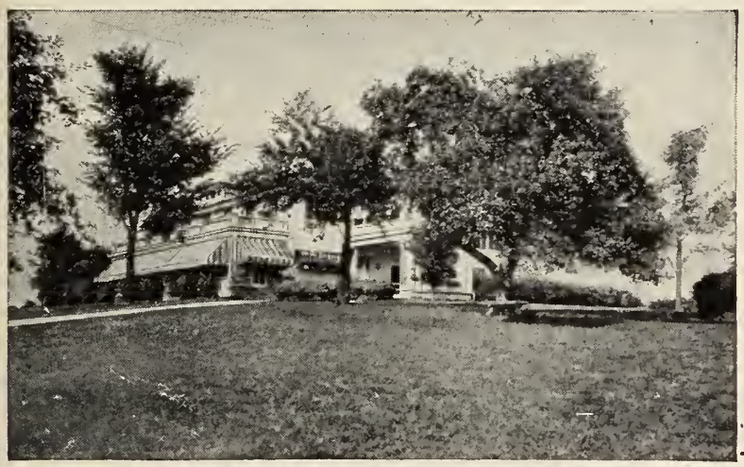


Louis Haughey, who joined the staff of the Battle Creek office early this year, immediately after graduating from the University of Michigan in Business Administration. His education was interrupted by war service in the Navy, much of it in the Pacific area. His hobbies are sailing and athletics.

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protozoölogy, hematology, mycology, and urinalysis in one book. Previously these subjects were treated separately and not at all co-ordinated. Now, all are grouped in a single volume. The text is full and complete without too much detail, and covers over 960 pages of meat that is standard and reliable for the laboratory worker, or the internist who does some of his own investigation. A "must" on all diagnostic office shelves.

CLINICAL DIAGNOSIS BY LABORATORY METHODS—A Working Manual of Clinical Pathology: By James Campbell Todd, Ph.B., M.D., Late Professor of Clinical Pathology, University of Colorado School of Medicine; Arthur Hawley Sanford, A.M., M.D., Professor of Clinical Pathology, Mayo Foundation, University of Minnesota, Senior Consultant, Division of Clinical Laboratories, The Mayo Clinic; with the Collaboration of George Giles Stilwell, A.B., M.D., Division of Clinical Laboratories, The Mayo Clinic. Eleventh Edition. 954 pages, with 397 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $7.50.

This is a compendium of laboratory methods useful in all forms of clinical diagnosis. Eleven editions have appeared in the forty years since the first one, and clinical methods and laboratory techniques have undergone almost unbelievable development. The arrangement is systematic. First, the microscope is described. That is the foundation of all clinical study. Then there are chapters on The Sputum, The Urine, The Blood, Clinical Chemistry, and chapters devoted to gastric and Duodenal Contents, Feces, Animal Parasites, Pus, Puncture Fluids, et cetera. Bacteriology, viruses, serodiagnosis, mycology, vaccines, antibiotics are all given sufficient attention. The text is clear and easily followed. The text is, as ever, a standard work.

MODERN CLINICAL PSYCHIATRY. By Arthur P. Noyes, M.D., Superintendent, Norristown State Hospital, Norristown, Pennsylvania. Third Edition. Philadelphia: W. B. Saunders Co., 1948. Price $6.00.

Since the previous edition of this textbook was published, there has been a remarkable increase in interest in the development of psychiatry. Much of this was occasioned by the reactions produced under the stress of the recent war, in both the civilian and military populations. The third edition of this text supplies a need occasioned by these recent psychiatric experiences. The book includes several very interesting introductory chapters which are of particular value to the beginner in psychiatry. These are:

"Mind—Its Development and Purpose"

"Psychic Energy and the Dynamics of Behavior"

"Mental Mechanisms and Motives"

"The Causes and Nature of Mental Disease."

The rest of the book follows the commonly used classification of the psychotic reactions. There are several new chapters:

"Psychotherapy"

"Shock and Other Physical Therapies"

"Child Psychiatry."

It should be noted that the major portion of this volume is given to the psychoses, and if there is any criticism, it could be based on the fact that only one chapter is given to the psychoneuroses. This deficiency is in part covered in the chapter on "Psychiatry and General Medicine," which describes the psychosomatic symptoms and illnesses. This book can be recommended as readable, interesting, and of considerable help to the beginner in psychiatry.—F. O. M.

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COUNCIL ON MEDICAL SERVICE CONFERENCE

(Continued from Page 889)

study. The officials of the Council indicated that this study would necessarily be done by the Blue Cross-Blue Shield Commissions, where it had already been placed. The final reports and plans for national co-operation will be reported back to another conference of the two commissions, and must finally be submitted and approved by the individual plans.

Action by the Council on Medical Service cannot change the orderly process which must ultimately be followed. This Conference was called "to consider the proposed consolidation of Blue Cross and Blue Shield." Ten western states formed an organization after the June 20 meeting to fight this merger and prevent it in their districts. No such merger was ever proposed—a working agreement was and is proposed.

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THE DANGERS that threaten the free practice of medicine in this country are fast becoming critical, and still we delay in uniting in decisive action to meet them.

We waste precious time in quarreling among ourselves over petty questions of local sovereignty. We amuse ourselves by setting up fantastic straw men, and dissipate our energies in knocking them down, while our enemies have been uniting against us in one national effort. We have thus far done no more than fight a series of rear-guard actions with small unorganized and unco-ordinated groups. I know of no more certain road to disastrous defeat.

Our national leaders seem to be purposefully blind to the social changes that are taking place. It is impossible to halt a movement by merely refusing to recognize its existence; and this movement toward extending the benefits of adequate medical care to all of our citizens has already gained too much momentum to be halted by any means. The last hope of American medicine lies in abandoning our present position in the rear of the column, where we have been holding back, and establishing ourselves firmly in the forefront, where we can guide and direct the movement into paths that are the best for our people as well as best for our profession. I emphasize that the welfare of our people must be given at least as much consideration as the welfare of the health professions. Too many physicians regard medical care as their exclusive prerogative. We must recognize that the consumer of medical care also has a great stake in it; and, if there has existed any doubt as to this, it should have been dispelled by the deliberations of the National Health Assembly, held in Washington early in May.

I shall offer no defense of the motives that prompted the organization of this assembly. They may have been, as has been charged, largely political. But however impure the motives, only a very stupid person could have listened to the discussions in the Section on Medical Care and come away unimpressed both by the strength and the determination of the groups committed to an *effective* program for prepayment of medical care. I emphasize "effective," because the preponderant opinion there expressed was that existing plans are acceptable only so far as they go, that they do not go far enough, and that, if they are to be fully acceptable as a substitute for compulsory government health insurance, the coverage they offer must be extended considerably, and must be uniform throughout the country. In fact, a resolution to the effect that *only* a compulsory government insurance plan could satisfy these criteria was proposed, and vigorously supported by the American Federation of Labor, the Congress of Industrial Organizations, Co-operative League of America, the National Co-operative Health Federation, the National Federation of Settlement Workers, the Committee for the Nation's Health, the American Association of Social Workers, the Physicians' Forum, the National Consumers' League, the National Women's Trade League, the United Mine Workers, the American Veterans' Committee, the National Farmer's Union, the Physicians' Committee for Improvement of Medical Care, the League for Industrial Democracy, and the Association for the Advancement of Colored People. This conclusion was not adopted, for the reason that adoption of any conclusion required the unanimous approval of the Steering Committee; and a single dissent was sufficient to defeat a proposal. But the array of strength behind this conclusion should convince even the die-hard Tories in the health professions that the threat of nationalization of medical care in this country is real, is acute, and soon will be, if it is not already, sufficiently great to precipitate action by the Congress. The press carried yesterday the news that the Wagner-Murray-Dingell Bill would not be reported out of Committee during this session of the Congress: but it also stated that

(Continued on Page 956)

Delivered at the Conference of Presidents and Other Officers of State Medical Associations, June 20, 1948.

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(Continued from Page 954)

hearings upon this bill would be resumed in March, 1949. So the bill is far from dead. The representatives of the people, in Congress assembled, are swayed by numbers of voters rather than by principles. Even discounting the smaller and the more radical groups demanding national health insurance, we still have the AF of L, the CIO, the National Women's Trade League, the United Mine Workers, and the Association for the Advancement of Colored People demanding national health insurance. These represent a lot of votes. I am sure they represent more votes than have yet been mustered in favor of equal rights for Negroes, and look what has been accomplished in this direction within a very short time! If this array of political strength is not enough to shock the medical profession out of its lethargy, then we are hopelessly lost and there is no use continuing the struggle.

What, then, will be the future of the voluntary prepayment plans for medical care—both commercial and nonprofit? Those demanding national health insurance were generous enough to state that the voluntary plans should continue in operation after the inauguration of national health insurance. This, of course, was but a courteous gesture, since it would be impossible for voluntary plans to compete with a government plan. The handicap would not be one of cost, because the voluntary plans can do the job cheaper than the government can. But the fact that the government plan would be supported at least one-third by tax money, and that everyone would have to pay this tax, whether or not he subscribed to a voluntary plan, would dissuade the taxpayer from supporting two plans at the same time.

Since it is impossible for voluntary plans to survive if and when national compulsory health insurance comes, we are going to have one or the other type of prepayment health insurance—not both. So, the future of the voluntary plans depends entirely upon the prevention of the enactment of national compulsory health insurance legislation.

This cannot be prevented through political manipulation. It is my considered opinion that, if left to popular vote, this legislation might pass today. Certainly the strength mustered in its support at the National Health Assembly surprised even its protagonists—and was something of a shock to me.

But this disastrous legislation *can* be prevented if the voluntary plans meet every *reasonable* demand for health insurance. I specify "reasonable demand" because, as all of us know who are familiar with the problems involved, some of the demands expressed at the National Health Assembly are impossible of fulfillment at the present time, and for some years to come.

There were unanimously adopted by the Medical Care Section seven criteria for measuring the effectiveness of prepayment plans in meeting the medical care needs of the people. I shall discuss only the more important of these as they point the goals which must be reached by voluntary prepayment plans if they are to be considered adequate to the peoples' needs.

The first criterion is "The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury." To meet this criterion, voluntary plans must be in a position to offer as comprehensive a coverage as the public demands, regardless of cost. Since many people neither desire so complete a coverage, and are unwilling or unable to pay its cost, this means that plans will have to offer more than one type of contract. This will not be at all difficult once a competent actuarial service is established. I can think of no good reason for limiting the offering of a prepaid medical care plan to a single type of contract. We must always, of course, offer a contract that is within the economic reach of the low-income groups who must bear all or part of its costs. But these large union groups are demanding a much more comprehensive service, and are willing and able to pay for it. We simply *must* be in a position to offer them a contract that meets their requirements, or we shall not only be forced out of business but also we shall have compulsory government health insurance as a reality instead of as a threat.

The fact that the fee schedules for the low-income group contracts are inadequate for the higher-income contracts need give no physician any concern. It is quite easy to arrange a separate fee schedule for each type of contract. For the higher-income groups, the fees should be higher, and should correspond to the fees normally charged such groups. The wealthier groups expect that—in fact, I am sure that they would demand it, because they do not want to be regarded as charity patients—and they are willing to pay the additional premium for their coverage.

(Continued on Page 958)



"Much has been done, much remains to do; a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

SIR WILLIAM OSLER, *Aequanimitas*

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(Continued from Page 956)

What can it matter to the participating physician whether the patient pays the bill from his private income, or whether the bill is paid by the medical care plans, so long as the amount paid corresponds with the fee customarily charged in that income level? Even if there is some objection to such a procedure, the alternative is to lose millions of potential patients to employe-benefit associations and medical co-operatives operating their own clinics and hospitals. I cannot stress too strongly the fact that this movement has already reached the point where the medical profession has the choice only of making a reasonable effort to meet the requirements of these large groups of consumers of medical care, or of watching the private practice of medicine in this country being rapidly strangled by either co-operative or government medicine. No other alternatives are left. All other alternatives have been lost in the ten or fifteen wasted years in which organized medicine has pursued an entirely negative course in dealing with this social problem.

The next point of the greatest importance is that these large groups will not be satisfied with anything short of uniform coverage for their members regardless of their place of residence. They simply will not deal with fifty-one separate Blue Shield Plans. Already the United Mine Workers, with 400,000 members, have a 10-cent per ton levy solely for health and welfare. As we assemble here, a union with more than 1,000,000 members is negotiating with a large industrial corporation for a 10-cent per hour increase in wages, to be devoted exclusively to a health and welfare program. Another union, with more than 1,000,000 members, has already appointed a medical advisory council to formulate a prepaid health program for its members, to be paid for by a similar 10-cent per hour raise in pay.

Is organized medicine guiding and directing these programs? It is not! I happen to know some of the members of this medical advisory council of this gigantic union. I can tell you that they are openly committed to government compulsory health insurance. Let me give you the names of some of them: Fred Mott, who is directing the government medicine program in Saskatchewan; Dean Clark, who is director of H.I.P. in New York; Jack Peters, who is secretary of the Committee of Physicians for the Improvement of Medical Care. I can tell you further that the plan for the medical care of this large union, which was proposed at the first meeting of this medical advisory council, was similar to that of the Health Insurance Plan of New York—the establishment of clinics in every center of this union population, and these clinics to be operated by salaried physicians. This association is on record as opposing such a plan for medical care.

Why was not organized medicine approached for advice and counsel in the establishment of these huge programs for prepayment of medical care? I'll let *you* answer *that* question. But doesn't it shock you, doesn't it give you a feeling of insecurity that the leadership of these great movements, which will exert the most profound effect upon medical practice in this country—that the leadership in these movements has slipped from the grasp of organized medicine? I can tell you that it disturbs me deeply, and that I am convinced that the cause is lost unless you take prompt and effective action to regain control of medical practice in this country. I say "regain" because I am afraid you have already lost it, whether you realize it or not. And you are not going to regain it through the methods you have followed during the past ten years.

Some three weeks ago I had a conference with one of the most powerful, if not the most powerful, labor leaders in the United States. This organization, of which he is the president, controls many labor unions with millions and millions of members. He has already started this movement for a prepaid medical care program in two of his largest unions, and he assured me that it would be carried on throughout the labor empire that he controls. I am violating no confidence when I tell you that he exhibited a strong bias against the attitude that organized medicine has displayed up to the present moment. His closest welfare advisers made it very clear to me that they would deal with the voluntary nonprofit prepayment medical care plans *only* if these plans met their requirements to a reasonable degree. They did not display an adamant insistence upon 100 per cent performance at once, but they set forth a few principles upon which they would not compromise.

The two most important principles upon which they would insist in full were uniform coverage in every area in which their members reside, and a single contract with one labor-management board regardless of the number of individual medical

(Continued on Page 960)

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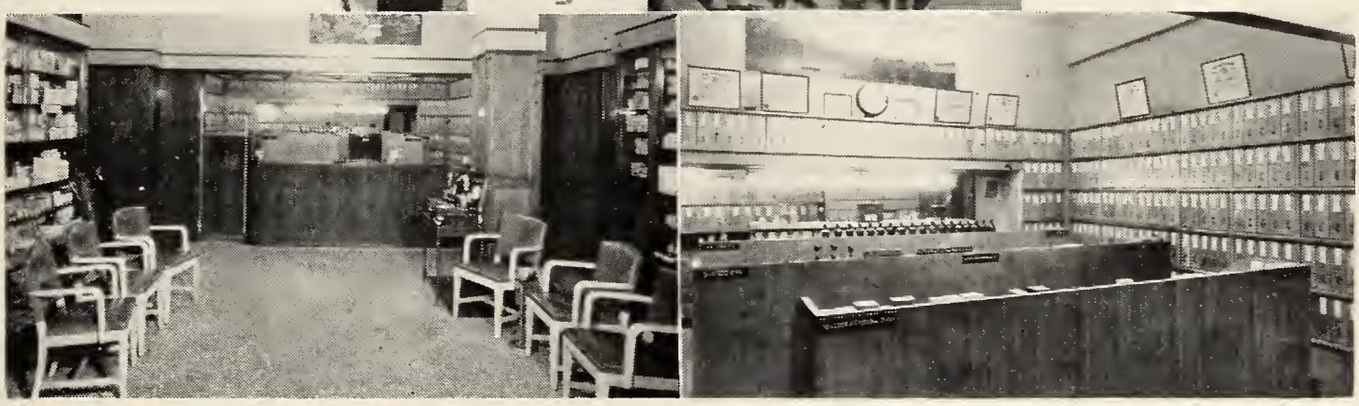




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(Continued from Page 958)

care plans which would be involved in providing the service. There would be no negotiation with reference to these two principles—we would have to accept them or reject them as they stand.

These gentlemen also made it clear that they were opposed to indemnity insurance and would accept this type of contract only as a temporary expedient. They are committed to the principle of the service contract.

These requirements can be met, and met easily. But they cannot be met so long as our vision is limited by the boundaries of the small areas in which we live and practice medicine. The problem is one of national scope, and it cannot be solved by state and county medical societies acting independently. I can assure you that you will not even be listened to, much less dealt with, upon any such basis.

Neither one of these requirements can be met, however, without the necessary machinery at the national level of Blue Shield Plans. You know full well that it would be impossible for fifty-one separate Blue Shield Plans to get together around a table and agree upon a uniform contract. Even if this were possible in one case, you must remember that different groups may demand different degrees of coverage, and this painful process would have to be repeated each time we were approached by a national group. The time required to effect such agreements would defeat us. These prospective clients demand an answer within days—not months.

For these reasons, only a National Service Agency, controlled by all the participating Blue Shield Plans, can possibly meet this urgent need. My own concept of such an agency is this:

1. It would be controlled by a board of directors elected by the participating Blue Shield Plans.

2. It would underwrite medical care programs of national scope, and, in turn, would pass on to each local plan concerned the share of the business that lay within the area of that plan.

3. If any local plan desired to accept the entire risk of additional coverage offered in any contract, it would be free to do so. If, on the other hand, any local plan declined to carry the additional coverage demanded, the National Service Agency would carry the added risk, and pay the local plan for all such service rendered.

4. The National Service Agency would work *only* through local plans. It would write no contracts in any area covered by a plan that did not involve two or more plans, and it would offer no contract of itself except in areas not covered by any Blue Shield Plan.

5. The National Service Agency would have no control over any local plan other than to see that agreements entered into with subscribers were carried out.

6. The existing organization of Associated Medical Care Plans would not be disturbed. The National Service Agency would be an underwriting organization, and *not* one of control.

As a physician, who is intensely interested in the future of medicine in this country, I cannot see the slightest danger in such a project. Each local Blue Shield Plan would preserve its present degree of autonomy, and the national agency would be one that *served* all the plans rather than one that *controlled* all the plans. And, don't forget one thing—it is either some such arrangement or be forced out of business. If we are not going to be in a position to serve these new millions of organized consumers of medical care, we had better announce that fact right now and liquidate our Blue Shield Plans. Sudden death is much preferable to a lingering, painful death; and slow death for us is certain—and maybe not so slow at that—unless we get in step with the rest of the country.

I mentioned earlier that straw men were being set up so that they could be knocked down. Perhaps the largest of these straw men is that this is just a scheme for Blue Cross to gain control of medical practice in this country. This is not only the largest of the straw men, it is also the most fragile. I work just as closely with the Blue Cross Commission as I do with the Blue Shield Commission. I have not seen the slightest evidence of any desire—much less, intent—on the part of the Blue Cross Commission to exert even the slightest control of the practice of medicine. The cry of "No Merger" has been raised against the two Commissions. I have been instructed by the Joint Executive Committee of the two Commissions to state that merger of Blue Cross and Blue Shield has never been considered. All that has ever been seriously proposed is a federation of the two groups for the single purpose of promoting the success of both. The leaders in Blue Cross believe, just as do the majority of leaders in Blue Shield, that we

(Continued on Page 962)

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(Continued from Page 960)

must effect enough co-operation between these two great organizations for us to offer prepaid medical and hospital care in one package. The public cannot understand why they should be forced to join two different organizations to protect themselves against the cost of illness—and, when you think of it, it is hard to explain. But joining hands solely for the purpose of offering prepaid health protection in one unit is a far cry from merging the two organizations under single control.

I beg of you not to be misled by any such vicious propaganda. So long as I remain in this position I shall defend medical practice just as zealously as I uphold the principles of Blue Cross. If there were any real areas of conflict between these two organizations, I would certainly discover them at once; and I can find none.

You did me the great honor last year of inviting me to address you at Atlantic City. I spoke to you very frankly at that time, pointing out the dangers to American medicine from within. That the majority of you approved my remarks, and believed in my complete devotion to our medical profession, is indicated by the fact that you have again invited me. I doubly appreciate this present honor, and I am again forcibly reminded of my great responsibility to the medical profession. I shall not, in the slightest, shirk this responsibility nor shall I ever compromise with my obligation to American medicine.

But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who would rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest.

If we get socialized medicine in this country, it will be organized medicine, and only organized medicine, that has brought this curse upon us. We, as physicians, will have only ourselves to blame. If I were among the group that wants socialized medicine in this country—if I were Channing Frothingham, or Ernst Boza, or Jack Peters, or Michael Davis, or Isidor Falk I would not exhaust much energy in making a great personal effort—I would relax and let organized medicine do the job for me. All that is necessary to bring socialized medicine to this country within a very short time is for organized medicine to pursue the same course that it has pursued for the past ten years.

The demand for more comprehensive medical care, and for an effective means of budgeting its costs, has grown, within ten years, from a whisper to a roar. Our people will not be denied much longer. If the medical profession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary nonprofit prepayment plans, and throw its influence squarely and honestly behind these plans, we are going to have compulsory government health insurance in this country within three years.

I give free medicine a lease on life of three years solely because other heavy financial commitments of the government will preclude the assumption of the additional burden of compulsory health insurance. The Marshall Plan and the rearmament program will keep the government, and the taxpayers, strapped for the next few years. But, within three to five years—and I think it will be nearer three—either these measures to restore peace will have been successful, or we shall again be in a war. I believe we shall have peace; and just as soon as the taxpayer is relieved from this terrific burden of his investment in peace, you may be sure the politicians will be ready to impose upon him the burden of a compulsory health insurance program—that is, unless by that time we have demonstrated that voluntary health insurance is a completely satisfactory answer to the problem. And I would emphasize further that, if we start right now, it will take at least two years to effect an organization that can do this job. We cannot afford to waste any more time in fruitless discussions that lead us nowhere. We must decide right now whether we are going to unite in this effort; and, if we are, we must cease all delaying and obstructive tactics.

Don't be lulled into a sense of security by such able studies on socialized medicine as have been made by the Brookings Institution, the National Industrial Conference Board, and other capable agencies such as these. Of course, every thinking person is convinced that socialized medicine would be a great mistake—a costly mistake both in money and in health. But this issue will not be decided by wisdom. It will be decided entirely by emotion. Like President Coolidge's preacher, who was "agin sin," everyone is against sickness and death. Only a small minority of our people can understand the

(Continued on Page 964)

MEAT...

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The all too prevalent practice of trimming the fat from many meat cuts and discarding it not only represents unnecessary economic, but also nutritional, waste. Fat is nutritionally valuable for several reasons, some of them well known, some only recently appreciated.

The fat of meat is an outstanding source of caloric food energy, small in bulk and low in moisture. It carries important fat-soluble vitamins, is well digested and absorbed, and endows the meal with satiety value making for real satisfaction. Meat fat furthermore contains certain unsaturated fatty acids which appear to play a significant and essential part in skin metabolism. Fat also exerts a sparing effect with regard to B complex vitamins.

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This survey of the nutritional significance of fat again emphasizes the valuable role of meat fat in the daily dietary.

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[1] Forbes, E. B., and Swift, R. W.: J. Nutrition *27*:453 (June) 1944. [2] Forbes, E. B.; Swift, R. W.; Elliott, R. F., and James, W. H.: J. Nutrition *31*:203;213 (Feb.) 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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dangers of socialized medicine. All they know is that they want everyone to have good medical care, and they are not capable of choosing between the various ways in which medical care can be better distributed. Only a *"fait accompli"* will convince them—and so we have only a short time in which to show them an accomplished fact.

It is useless for the medical profession to undertake the education of our people to the dangers of socialized medicine. Our public relations have been so miserable in the past few years that a majority of our people suspect us of having only a selfish, personal interest in this question. I honestly believe that the medical profession does more harm than good when it attempts to decry socialized medicine—our motives are too suspect.

Don't be misled with such absurdities as the assurance that the government cannot make you practice medicine if you do not want to. You see what has happened in England. The members of the British Medical Association voted at first to have nothing to do with government medicine. The majority was heavy, 80 per cent pledging themselves to remain outside the government plan. But as the deadline for participation approached, British physicians, by a small majority, voted to accept the government plan.

How long can you hold out in a strike against the government? How many of you could stick it a year with no income? And how many of you would stick it if you saw a minority group collecting all the gravy? You are trained in medicine. How many of you would be willing to forsake medicine and embark upon another career?

Don't let anyone fool you! If government medicine comes, 90 per cent of you will be forced by circumstances to accept it, no matter how bitter a pill it will be for you to swallow. So, the only way to prevent this tragedy is to stop it before it arrives—there is little you can do about it after it comes. The medical profession *can* prevent this tragedy, but only by positive action that will meet the reasonable demands of these large groups. Consistently negative action has brought us to this critical juncture and has played directly into the hands of the enemies of free medicine. Time is running against us. We cannot longer delay.

This convention, which is about to open, promises to be the most important in the hundred years of existence of the American Medical Association. The great work of the past hundred years can be undone overnight by unwise action during this week. I beg of you to weigh carefully the issues that will be presented. I ask you to weigh them in the light of the events of the past few weeks. I am as certain as I am that I stand here that if this convention fails to encourage and support the expansion of the Blue Shield movement, the death knell of free medicine in this country will have been sounded.

PROGRESS ? —YES

The doctor secluded in his ivory tower far above the struggling crowds is apparently becoming obsolete. There are encouraging signs that the medical profession in Michigan is developing a social consciousness which is taking us into many a field beyond the pure scientific practice of medicine. Pioneer in a great host of medical and medico-socio-economic projects, the Michigan State Medical Society, leader in the nation in rheumatic fever control and in rural health studies, is about to enter the field of community health councils.

The demand for some type of co-ordinating organization in the field of health activities on both state and county level has been expressed recently with increasing fervor.

County medical societies, local health departments, and local civic organizations often fail in their efforts in the health field for lack of co-operation and co-ordination. The Rural Health Conference held in Lansing this month offered an excellent example of the potentialities of co-operative effort on the state level. Physicians, educators, farm leaders, health officers, and a host of others interested in rural health sat down and worked together on their common problems. It was stimulating and inspiring. This group of over 400 persons representing over forty organizations passed unanimously a resolution urging the Michigan State Medical Society and the co-sponsors of the conference to study the ways and means of setting up similar co-operative organizations on the county level which would assist in co-ordinating the health activities of all local organizations. The resolution also urged that this might be accomplished most effectively by a State Health Council with an executive director who would be an expert in the field and who would have as his prime objective the rendering of assistance to local community groups in the organization of their community health councils.

It is interesting that as long ago as November, 1947, the rural health committee of the Michigan State Medical Society recommended that funds be appropriated for this purpose. The Council of the Society approved of the project and set aside $7500 to assist in the organization of such a State Health Council. Dr. A. S. Brunk of Detroit, president of the organization bearing the name of the Michigan Health Council (in existence for several years but having a more limited field of operation), then called and held a meeting of representatives of many state organizations interested in the health field.

Most recent encouragement came from the members of the corporation of the Michigan Medical Service. At a meeting on September 20, the members advised the Board to match the appropriation of the State Medical Society to assist in the project. With this encouragement, Dr. Brunk has called a meeting of the steering committee to be held in October. Several large lay organizations are represented on this committee which will map out the plans and prepare for early action.

It is in this field of practical public service—on both state and county level—that the medical profession in Michigan will find its most powerful voice in practical public relations.

Progress? — Yes

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HIGHLIGHTS OF THE COUNCIL MEETING

Session of July 22-23-24, 1948

• Monthly financial reports and bill payable were presented, studied, and approved.

• The Council instructed that copies of minutes of all MSMS committee meetings are to be forwarded to each MSMS Councilor, routinely, in future.

obtain from government agencies the government reimbursable cost formula for hospital care of wards of government.

• The Finance Committee of The Council reported that it had received a check for $21,421.73 from



Council Meeting of July 22-23-24, 1948

• A Heart and Rheumatic Fever Day, recommended by the Rheumatic Fever Control Committee, was authorized for Saturday, March 26, 1949, following the third Michigan Postgraduate Clinical Institute. The Heart Conference will be held in the Book-Cadillac Hotel, Detroit.

• Reports accepted from the Cancer Control Committee, Medical Services Advisory Committee of State Vocational Rehabilitation, Committee on MSMS Constitution and By-Laws, Rheumatic Fever Control Committee, Committee on Study of MSMS Dues Structure, Permanent Conference Committee with Michigan Hospital Association, and Michigan State Nurses Association, and progress report of Public Relations Committee.

• Action by AMA House of Delegates on the Michigan resolution concerning AMA health coverage of its employes was reported by R. L. Novy, M.D., Detroit, one of the MSMS Delegates to AMA. He also reported on the June 20 Chicago meeting of the Boards of Blue Cross-Blue Shield where joint activity of these two services was discussed: Co-operation and reciprocity is necessary to establish or create a national enrollment organization to implement the hospital and medical coverage of employes of national employers.

• Joint meeting with Michigan Hospital Association's Board of Directors was held, with a discussion of mutual aims and purposes, including a desire on the part of the Hospital administrators to

the Michigan Society for Crippled Children and Adults, Inc., for the Michigan Rheumatic Fever Control Program of 1948; it also recommended that bonds in the Grace W. Biddle estate be sold and the estate be liquidated in cash (one-half to go to the Michigan State Medical Society and one-half to the University of Michigan for postgraduate medical education) which recommendation was approved by The Council.

• The Treasurer's report as of June 30, 1948, was presented by A. S. Brunk, M.D., and approved by The Finance Committee and by The Council.

• The Public Relations Counsel presented report of the Research Council for Economic Security which delineated the spread of cash sickness programs among the states (acceptance by California, Rhode Island, New Jersey) and the introduction of legislative bills in thirteen other states. The Council disapproved any cash sickness plan and instructed that this action be implemented as widely as possible.

• The Publication Committee studied the report of the CMAB Advisory Committee re gains and losses in state journal advertising for the first six months of 1948. The Committee recommended a number of improvements in JMSMS, which were adopted by The Council.

• The Annual Report of The Council was pre-

(Continued on Page 968)

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 966)

sented, amended in several paragraphs, and approved for referral to the House of Delegates.

• The monthly reports of President P. L. Ledwidge, M.D., President-Elect E. F. Sladek, M.D., Secretary L. Fernald Foster, M.D., General Counsel J. Joseph Herbert, and Public Relations Counsel H. W. Brenneman were accepted.

• The resignation of Councilor E. R. Witwer, M.D., Detroit, was accepted with profound regret. The Council confirmed the appointment of his successor, Eugene A. Osius, M.D., Detroit, made by President Ledwidge.

• The Council recommended to the Committee on Constitution and By-Laws that it create a Committee on diabetes as part of the MSMS Committee on Preventive Medicine.

• The Annual Reports of all MSMS Committees were referred by The Council to the House of Delegates.

• Appointments to the MSMS Hospitality Booth, on the occasion of the Annual Session in Detroit, composed of the twenty-one Councilors, were made.

• The Council appointed E. W. Blanchard, M.D., Deckerville, as Chairman of the County Secretaries Conference for January, 1949, in place of J. Bates Henderson, M.D., resigned. Dr. Henderson is moving to Berea College, Kentucky.

• Joint meeting with Commissioners of the Michigan Mackinac Island State Park Commission re restoration of the Early House on Mackinac Island into the Dr. William Beaumont Memorial Shrine. This matter was referred to the MSMS Beaumont Memorial Committee, F. A. Coller, M.D., Ann Arbor, Chairman.

• Joint meeting with Michigan Crippled Children Commission included discussion of six matters of mutual interest.

• Proposed Veterans Hospital in Ann Arbor. The Council instructed that a letter be written to the Board of Regents and the Dean of the Medical School of the University of Michigan inquiring into the need for this ambitious federal project, in view of the fact that the number of beds available in Veterans Administration hospitals for service-connected cases is already far in excess of present need or of any demand which may reasonably be anticipated—the great majority of patients in these hospitals being persons who have no service-connected disabilities or illness whatever; further, that the present facilities of the University Hospital are adequate for teaching purposes, as well as for the care of indigents referred under state law.

• Complaints under Veterans Administration home town medical care program. At the recommendation of R. L. Novy, M.D., Detroit, President of Michigan Medical Service, The Council authorized the Chair to appoint an anonymous committee to investigate complaints in the VA-MMS program.

• Joint meeting with the President of the American Hospital Association, Mr. Graham Davis of Battle Creek, resulted in a further discussion of unnecessary Veterans Administration hospital building. Mr. Davis stated that VA now has 118,000 beds and that the Medical Advisory Committee to the VA recommends that the top figure be no greater than 120,000 beds; further, that 8,000 beds are now closed because staffs cannot be procured.

• The Chair thanked all Councilors for their extreme patience at this three-day session, which included four meetings constituting seventeen hours and twenty-six minutes of conference.

VETERANS ADMINISTRATION INTERNSHIPS

A limited number of internships in Veterans Administration hospitals will be offered qualified medical graduates.

The internships will be limited to the 75 VA hospitals now offering residency training programs in cooperation with 59 Class "A" medical schools over the country. They will be further limited to those hospitals which have bachelor quarters available on the station grounds. A survey is in progress to determine what housing is available.

Two types of internships will be available:

(1) "Straight," for surgery, general medicine and other "straight" subjects and

(2) "Rotating," in which interns study, under a rotating schedule, surgery, general medicine and other related subjects. Arrangements will be made for affiliated training in other than VA hospitals for obstetrics and pediatrics. Such affiliated training may not involve more than 20 per cent of a year. The hospital at which such affiliated training is secured must be approved for internship by the Council on Medical Education and Hospitals of the American Medical Association.

"Mixed" internships will not be offered.

Internships will be for one year, subject to reappointment for one year, if desired and recommended by the local dean's committee. The deans' committees, composed of members of university faculties or prominent local doctors, supervise the residency training program and will also supervise internship training.

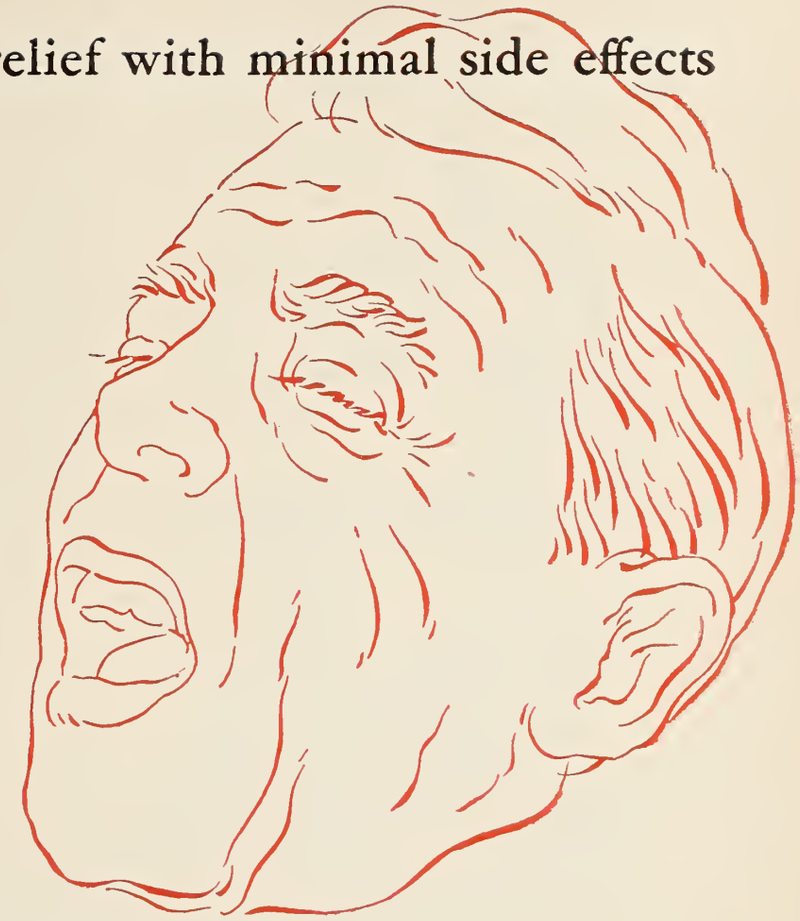
Annual pay for interns will not exceed $1,800 a year. Quarters, subsistence and laundry will be furnished. The stipend for interns at each hospital will be determined by VA's chief medical director on recommendations of the deans' committees and in conformance with the existing scale of remuneration for interns in the locality.

Interns will be appointed in the VA in accordance with the national policy for all medical schools and hospitals, once each year, on November 15, their tour of duty to begin the following July 1 or January 1 following July 1.

The new program is under the supervision of Dr. Paul B. Magnuson, VA's chief medical director, and Dr. Edward Harvey Cushing, assistant medical director for research and education in VA's Department of Medicine and Surgery. Dr. Cushing, formerly associate clinical pro-

(Continued on Page 970)

symptomatic relief with minimal side effects



in
hay fever

PYRIBENZAMINE

During the last two pollen seasons, the effectiveness of Pyribenzamine hydrochloride in hay fever has been demonstrated repeatedly . . . 84% of 288 cases[1] — 78% of 588 cases[2] — 82% of 254 cases.[3]

Side effects are few and for the most part mild: — "No serious side effects have been noticed in any patients."[1] "In our opinion, reactions to Pyribenzamine are minimal and seldom necessitate stoppage of the drug."[4] The usual adult dose is 50 mg. four times daily.

1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

Pyribenzamine Scored Tablets, 50 mg., bottles of 50, 500 and 1000.
Pyribenzamine Elixir of 5 mg. per cc., bottles of 1 pint and 1 gallon.

• CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

Ciba

PYRIBENZAMINE (brand of tripelennamine)—Trade Mark Reg. U. S. Pat. Off.

2/1371M

VETERANS ADMINISTRATION INTERNSHIPS

(Continued from Page 968)

fessor at Western Reserve University, Cleveland, Ohio, handled many of the details in establishing VA's residency training program and is in charge of VA's research activities into the causes and cures of little-known diseases among veterans.

The seventy-five VA hospitals which now have residency training programs and the universities or other agencies with which they are affiliated include Dearborn, Michigan, with Wayne University, and Fort Custer with the University of Michigan.

For further information, communicate with the Dean of the University.

RESIDENCY TRAINING IN PSYCHIATRY AND NEUROLOGY

Veterans Administration has immediate openings for at least one hundred young doctors interested in taking residency training in psychiatry or neurology or both, Dr. Paul B. Magnuson, chief medical director, has announced.

VA hospitals offering these residencies are situated in almost every section of the country. All are under supervision of the deans' committees, mostly composed of members of university faculties of Class "A" medical schools.

Applicants for residency training in these fields must be citizens of the United States, graduates of a school of medicine approved by VA and the Council on Medical Education and Hospitals of the American Medical Association, and have completed an internship acceptable to VA.

In general, these residencies cover a three-year program of specialty training, although one- and two-year programs also are available at most of the hospitals.

Junior or first-year residents must have completed a satisfactory internship and be considered ready for specialization. Intermediate or second-year residents must have the qualifications of a junior resident and the equivalent of one year's training in the specialty. Senior residents must have the qualifications of a junior resident and two years' training in the specialty.

Interested doctors may obtain information and application forms regarding the residencies by writing the Chief Medical Director, Veterans Administration, Washington 25, D. C.

Residency selection and residency grades for the individual are recommended by the dean's committee supervising the program at the VA hospital in which the applicant desires to train.

ARMY HOSPITAL BEDS SET ASIDE FOR VETERANS

A total of 3,035 beds in Army hospitals throughout the United States have been allocated for treatment of veterans, Major General Raymond W. Bliss, Surgeon General of the Army, has announced. The allocations were made at the request of the Veterans Administration.

Beds allotted for veterans may be used partly for treatment of chronic disabilities, with 325 set aside specifically for tuberculosis cases at Fitzsimons General Hospital in Denver. None of the beds allocated will be used for patients who could be treated in domiciles.

The list of hospitals where veterans will be assigned beds: Army and Navy General, Hot Springs, Arkansas, 175 beds allocated; Brooke General, San Antonio, 400; Fitzsimons General, Denver, 700; Letterman General, San Francisco, 175; Madigan General, Tacoma, Washington, 350; McCornack General, Pasadena, 100; Oliver General, Augusta, Georgia, 125; Percy Jones General, Battle Creek, Michigan, 200; Tilton General, Wrightstown, New Jersey, 275; Valley Forge General, Phoenixville, Pennsylvania, 175; Walter Reed General, Washington, D. C., 50; William Beaumont General, El Paso, 150; Fort Benning Station, Columbus, Georgia, 50; Fort Belvoir Station, Accotink, Virginia, 35; Fort Bragg Station, Fayetteville, North Carolina, 50; and Spokane Air Force Base Station, Spokane, Washington, 25.

BLUE SHIELD PLANS RETURN CAPITAL LOANS

Within the last ninety days two Blue Shield plans have returned the full amount of money advanced by individual physicians for their original capitalization.

Ohio Medical Indemnity, Inc., sponsored by the Ohio State Medical Association, has redeemed $100,000 in preferred stock which was purchased by individual members of the profession when the plan was organized two years ago. The payment was made possible by sound management and a rapid rate of growth. The Ohio plan, with 342,665 members enrolled on March 31, ranked fifth in size among Blue Shield plans.

Mutual Medical Insurance, Inc., sponsored by the physicians in Indiana, has redeemed certificates in excess of $80,000, also purchased approximately two years ago when the Indiana plan was established. The ability to return capital loans in Indiana closely parallels that of Ohio, Blue Shield in Indiana having acquired a total membership of 156,816 on March 31.

MISSISSIPPI VALLEY MEDICAL SOCIETY

The 13th Annual Meeting of the Mississippi Valley Medical Society at Springfield, Illinois, September 29, 30 and October 1, will feature three full days of lectures and exhibits by members of the faculty of a large group of the leading medical schools and hospitals of this country. The medical schools represented include Washington University, St. Louis University, University of Chicago, University of Minnesota, Northwestern University, University of Illinois, State University of Iowa, Baylor University and Loyola University.

The entire scientific program and forty technical and scientific exhibits have been planned to appeal to the physician in general practice. *No registration fee* will be charged and every ethical physician is cordially invited to attend. The entire meeting will be held in the Abraham Lincoln Hotel.

A detailed program may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Illinois.

We no longer

trust to

fickle winds...





Nor to commonly faulty diets. Today, even the best diet can be bettered in vitamin intake with multivitamin supplementation. Nowadays, the vitamins fundamental to development, organic function and fitness can be administered — *economically* in definite quantities — for therapeutic and prophylactic purposes. Upjohn prepares prescription vitamins in a full range of potencies and formulas to meet the needs of medical and surgical practice.

Upjohn
KALAMAZOO 99, MICHIGAN

fine pharmaceuticals since 1886

Upjohn Vitamins

Cancer Comment

THE INDUSTRIAL PHYSICIAN AND CANCER

The industrial physician should be a potent force in the campaign against cancer. In his own sphere, he is alert to the possibilities of malignancy created by such carcinogenic substances as may be used in the manufacturing processes under his jurisdiction. He needs no encouragement to pursue the multiple ramifications of the study of industrial cancer. Occupational malignancy is, however, a small problem statistically. The larger problem, by far, is to deal with those malignancies which have no demonstrable relationship to occupation. In this accord, the industrial physician is placed in a strategic position by reason of the large number of people with whom he comes in constant, daily contact.

The respected doctor in industry is called upon for much advice. Many of the people he sees will not consult their own physician for the particular complaint under consideration. The complaint may seem so minor or of such recent origin that the sometimes formidable project of consulting a doctor is postponed. For many reasons it may be simpler to consult the doctor at the factory. The employe wants "just a little advice," the service is free, no time is lost from work, the plant doctor is available. Diplomatic and sympathetic handling of such visits is necessary, but, more importantly, the advice given should be correct. In dealing with a person over forty-five, the possibility of malignancy being the basis of a complaint should be foremost in mind. The employe must be counselled to seek proper and prompt attention. He must be told of the possible seriousness of the situation in one-syllable words.

The employe who presents himself with a complaint about his health, in most instances, alleges an industrial connection. It is not enough to decide whether or not it is of industrial origin and to treat him if it is and forget him if it isn't. A chronic cough, loss of appetite, or weakness may represent an early malignancy. If the industrial physician disclaims its connection with the manufacturing process, the employe may wait before consulting his family physician and the chance for cure will be lost. A few moments more spent in obtaining the history and an additional examination, such as a rectal examination, may substantiate a suspicion. A note to the family doctor concerning your findings of your suspicions is more than a courtesy, it is an obligation.

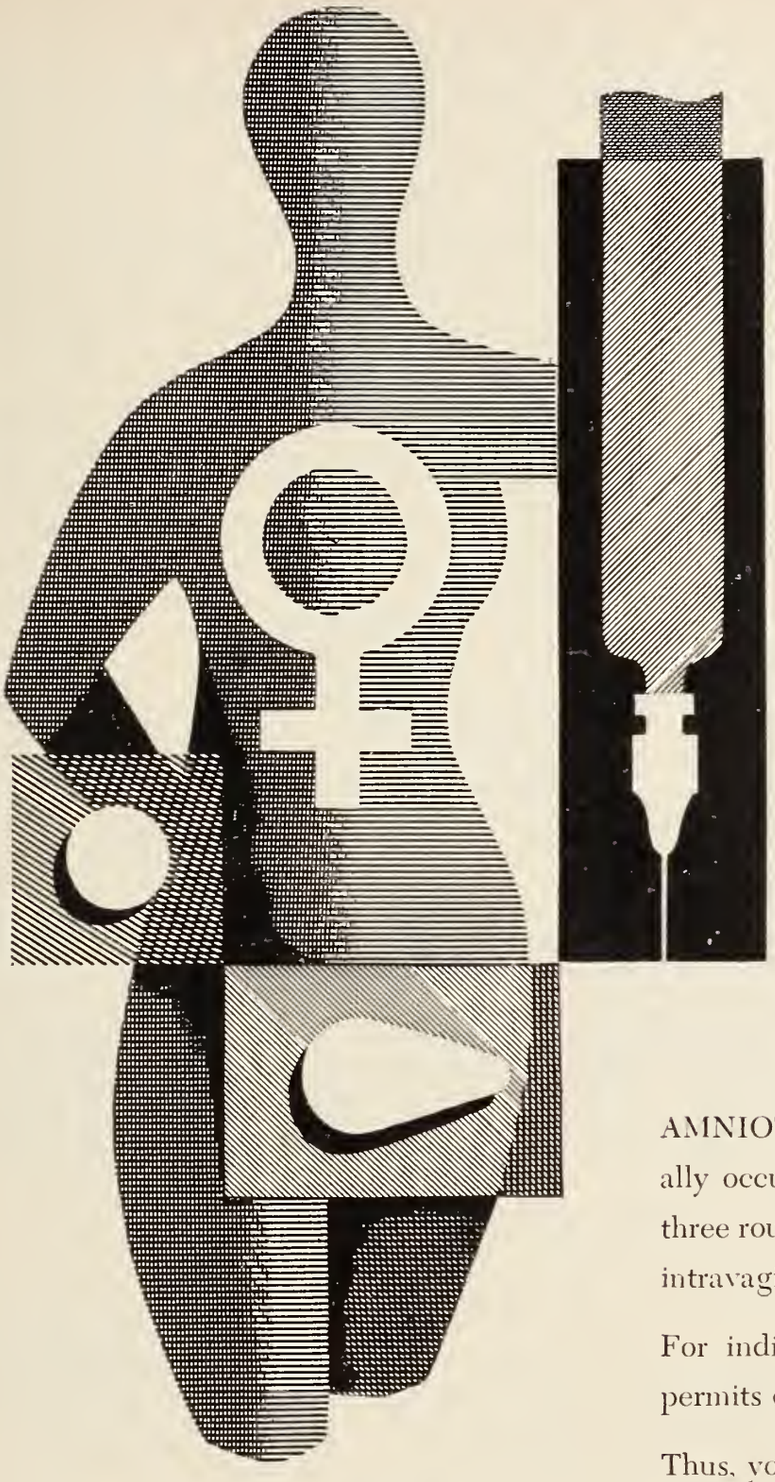
In the course of the routine pre-employment examination, a rejected person should be appraised of the reason for this rejection. He should be encouraged to seek the services of his own physician for further investigation. A study of the record sheets of visits to first-aid departments should be made frequently. Employes who, with increasing frequency, patronize the first-aid station for indigestion, headaches, weakness, dizziness, cough, and the like, should be called in for a talk with the plant physician. A request for a job transfer by a middle-aged employe who finds he does not have the physical stamina of yesteryear merits a few minutes of judicious questioning into his symptomatology. Does his physical deterioration represent the early cachexia of hidden malignancy?

In the course of passing upon requests for sick leaves, a physician occasionally encounters individuals who intend to travel to the widely advertised "cancer clinics," run by quacks, for the treatment of lesions which may or may not be malignant. Positive and specific advice should be given them. If the employe is reluctant to accept your advice and is a member of the UAW-CIO, suggest that he consult the Health Clinic of the UAW-CIO before proceeding further. Each local of the UAW contributes to the support of this clinic in Detroit, and its services of a diagnostic nature are free to union members. Its staff is competent, and the union employe can and does accept its recommendations with confidence.

The periodic physical evaluation of executives is a part of the medical program of most industries. Perhaps the most satisfactory result of such examinations is the search for the presence or absence of cancer. X-rays of the gastrointestinal tract produce relatively unequivocable results and are more satisfactory than the evaluation of cardiac status by an electrocardiogram. A sigmoidoscopic examination is probably of more consequence than the basal metabolic rate determination.

The medical director should be a regular contributor to company news sheets. In addition to

(Continued on Page 980)



only one can be used by three routes

AMNIOTIN is the only complex of naturally occurring mixed estrogens for use by three routes—intramuscularly . . . orally . . . intravaginally.

For individualized therapy, AMNIOTIN permits dosages of 1,000 to 50.000 I.U.

Thus, you can treat wide variations in the degree and type of symptoms with a marked uniformity of clinical response.

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complex of naturally occurring mixed estrogens

Ampuls and Vials
Capsules (oral)
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SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Say you saw it in the Journal of the Michigan State Medical Society

PR in Practice

"What's being done in Public Relations in the Medical Society?" This question is sometimes asked—particularly when no dramatic demonstration has recently taken place. The answer can only be indicated, for the activities of the State Society are legion in this field. However, the strong, steady flow of information to the people never ceases. It's a continuing thing. And that's one of the secrets of good PR.

Newspapers

Keeping people informed through newspapers is one of the services which has become routine in the PR office, and yet it performs a most necessary service. Some of these day-by-day and week-by-week services are as follows:

A monthly three-column feature release, complete with pictures, on such subjects as Rheumatic Fever Control Program, Medical Associates, Michigan Rural Health Conference, etc., are sent to all newspapers in Michigan in matrix form. These releases have been published in hundreds of newspapers to date.

More than thirty special news releases and three blanket coverage stories were sent out on the Michigan Rural Health Conference, as well as forty special advance publicity stories on the 83rd Annual Session and Postgraduate Conference of September 22-24, 1948. The Health News Column continues in approximately 200 newspapers weekly, and the third ad of the advertising series appeared recently in newspapers throughout the state.

Radio

A study was conducted by mail to determine the local use being made by radio by county medical societies. Results of the survey indicated that approximately seven of these societies utilize radio. The lengths of the programs range from spot announcements to full fifteen-minute programs.

The "Tell Me, Doctor" program has increased to twenty-three stations in Michigan and seventeen stations in other states. This is a DAILY program.

Cinema

The Michigan State Medical Society moving picture, "Lucky Junior," was completed and previewed at the Jam Handy Studios in Detroit, and at the midsummer session of The Council on July 23.

The picture, which deals with the subject of child immunization, carries a youngster from the time of birth up to manhood. It points out his increased chances today as contrasted with yesterday of living to a ripe old age, due to advanced medical knowledge and skill and programs sponsored by the medical profession.

At the present time "Lucky Junior" is being distributed to 400 motion picture theaters in Michigan for showing on their regular programs this fall.

Following this run in the commercial theaters the picture will be reproduced on 16 mm. film for showing before small groups throughout the state.

Sex Education

Thirteen sex education scripts, the full series, have been completed. These scripts are now being recorded on transcription by the Department of Visual and Auditory Aids of Wayne University. Upon completion, these records will be auditioned in Lansing High Schools.

If the recordings prove successful in this typical school system, they will be introduced into high schools throughout the state, thanks to co-operation of the Michigan Department of Public Instruction.

Brochures

The Woman's Auxiliary Public Relations brochure was completed and distributed to officers and committee chairmen of all county auxiliaries and the State Auxiliary. The brochure outlines various specific projects which the Woman's Auxiliary is interested in carrying through, such as the promotion of Health Month, Immunization Month, the Nurse Recruitment program, Loan Funds for Medical Students, Medical Associates, the Blue Cross-Blue Shield Community Enrollment Plan, et cetera.

The Medical Associates brochure has been completed. It is now being distributed to school administrators, advisors, and libraries, as well as to the hundreds of interested parties who have requested copies of the booklet. There is no question now that the publishing of this brochure will be of great service to the schools in their vocational guidance program. It will mean much toward the recruitment of necessary workers in the health field—the need being dramatically evident.

Experience is the Best Teacher

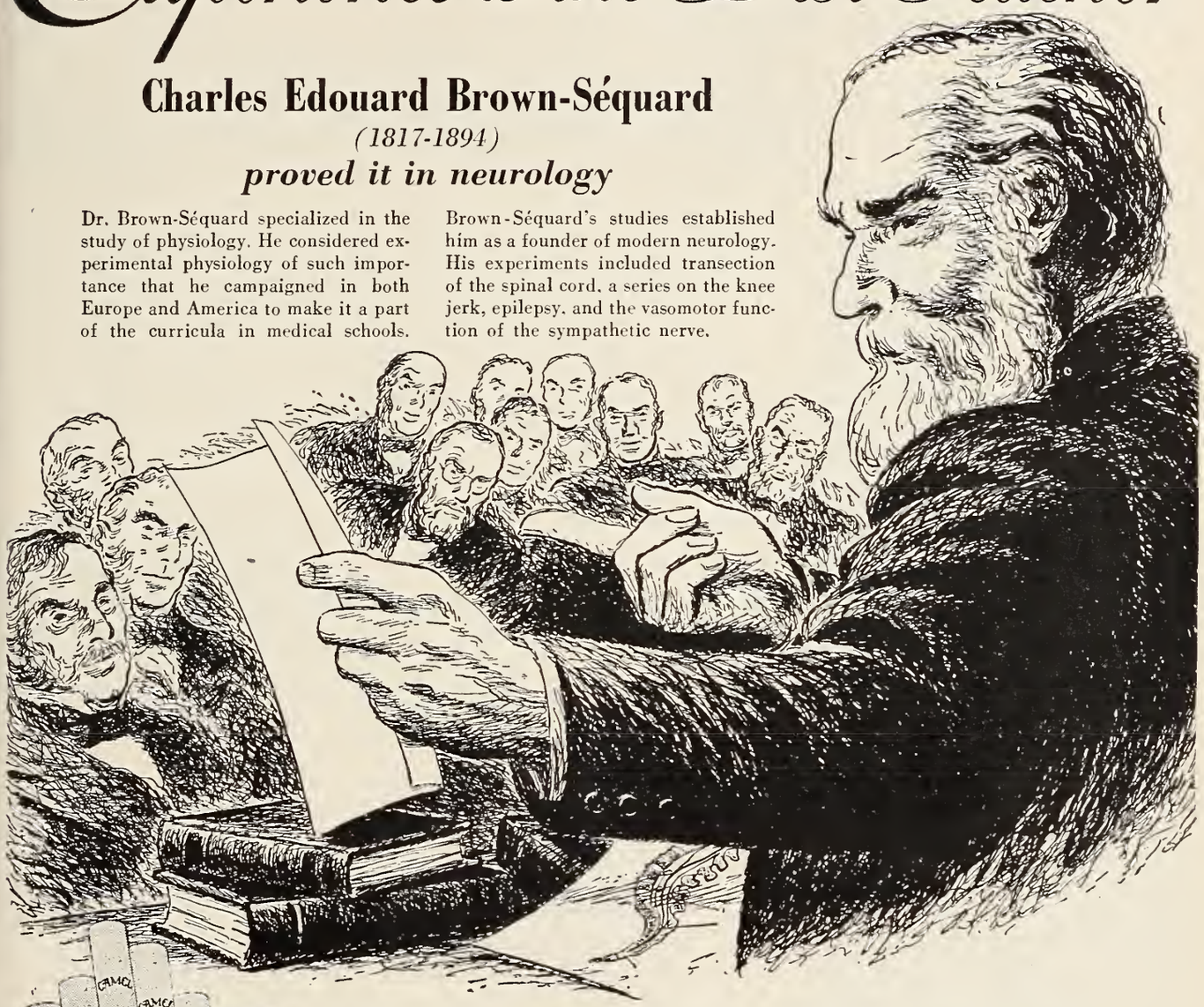
Charles Edouard Brown-Séquard

(1817-1894)

proved it in neurology

Dr. Brown-Séquard specialized in the study of physiology. He considered experimental physiology of such importance that he campaigned in both Europe and America to make it a part of the curricula in medical schools.

Brown-Séquard's studies established him as a founder of modern neurology. His experiments included transection of the spinal cord, a series on the knee jerk, epilepsy, and the vasomotor function of the sympathetic nerve.





Experience is the best teacher in cigarettes, too

YES! Experience counts. Millions of smokers who have tried and compared many different brands of cigarettes found from experience that Camels suit them best. As a result, more people are smoking Camels than ever before.

Try Camels! See how *your* taste appreciates the rich, full flavor of Camel's choice, properly aged, and expertly blended tobaccos. See if *your* throat doesn't welcome Camel's cool mildness.

Find out for yourself why, with millions of smokers, Camels are the "choice of experience."



R. J. Reynolds Tobacco Co.
Winston-Salem, N.C.

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

Editorial Opinion

THE NOVEMBER ELECTION

THE JOURNAL definitely is not in politics; as long ago as early in 1933 various policies were determined by the Editorial Board. Number 1 item on the list was a consideration of the political policy of our magazine. It unanimously was decided there would be none, that one person, the editor, should make political comment when deemed advisable.

This policy has been lived up to in every way; very occasionally have we had anything to say regarding strictly political matters. In the establishment of this policy we had before us another medical magazine, published under the direction of one of our larger states. The editor each month used several pages to express his views on various economic matters, chiefly of a political nature. We never were in accord with this program, though the editor was a good friend of ours.

But times have been changing, it seems; we now have arrived at the point where our very existence as a "free" profession is challenged—it has been challenged for a long time. We have defended our position, our very right to an untrammeled existence; we have gone before national legislative bodies, attended committee "hearings" time without end and number. We believe all this labor has not been without its reward, in some degree, since we have interested millions of our population in our behalf; a very large proportion of the daily and weekly newspapers have come to help us bear the standard of a nonregimented profession; yet the thing goes on, aided and abetted by federal officials of high rank and promoted by a largess from the federal treasury that has assumed no mean proportions.

The thousands of "employes" now engaged in "an advancement of health measures," most of them not of the medical profession, have assumed regimental proportions; it is but natural that they would like to continue in their "soft" jobs. On occasion they have not stopped at the borders of our country in their endeavors to promote what commonly is called "socialized medicine." Witness the not-too-long-ago attempt to promote such a program in Japan.

They seem to have had the backing of the "administration" in many of their maneuvers; certainly they had a large "expense account!"

As of today, when the election is not far away, the leaders of this group are very active—some openly and some furtively. We still hear of Falk, Davis, et al, and know they are not quiescent.

We are making no recommendations as to how any Indiana physician should vote, come next November; we recommend only that they keep both eyes and ears open, that they may know just what is going on. At this writing, but one presidential candidate has been named; he publicly has proclaimed that he definitely is not in favor of socialized medicine; it remains to be seen what the other major candidate will have to say.

Someone recently said that American Medicine is at the crossroads; we believe it is far more grave than that—we believe that American Medicine has its back to the wall and must fight it out. Certainly we do not wish to face the plight that is now confronting British Medicine; those who have been on the ground there have made observations that are most astonishing, to say the least.

The Journal has but one recommendation to make, and that is that when you go to the polls next November, do not approach the polling place with the thought in mind of voting Republican, Democratic, or whatnot—go there with the determination to vote for **American Medicine.**

—Editorial, *Journal of the Indiana State Medical Association,* August, 1948.

TAKING CARE OF THEMSELVES

While Great Britain turns toward "socialized medicine" and President Truman continues, in his political speeches and in his message to Congress, to call for a federal health program based on health insurance, evidence mounts that the American people can and will take care of themselves.

They need no bureaucratic interference nor paternalistic supervision.

The Blue Cross, with which the Michigan Hospital Service and the Michigan Medical Service are affiliated, now has a national enrollment of more than 30,000,000 in hospital care plans and more than 7,000,000 in medical service plans.

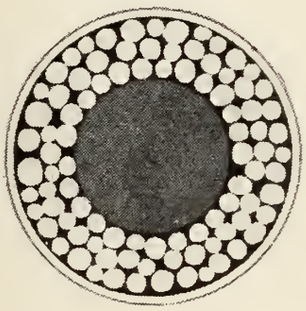
In Michigan alone, there is an enrollment of

(Continued on Page 978)

THE *Coating* MAKES THE DIFFERENCE



The Barlow-Maney Enteric Coating* employs a rationale adapted from the physiology of digestion. Specially developed, unique, *in vitro* tests demonstrate its effectiveness—clinical radiography confirms it.
The coating of Barlow-Maney Tablets Aminophylline Enteric Coated is described in New and Nonofficial Remedies, 1946.



LABORATORY TEST

Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

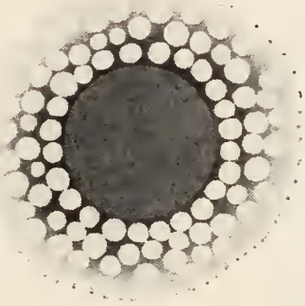


Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.

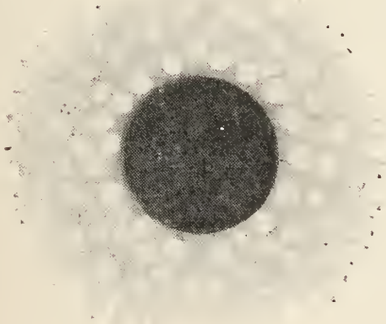


Fig. 3 — Complete disintegration.

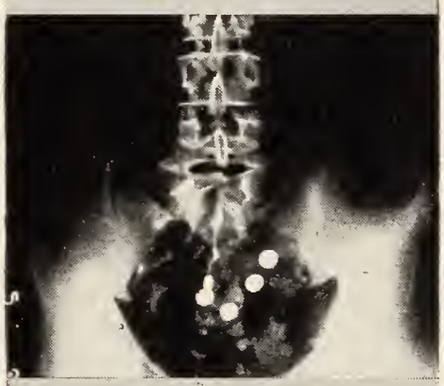
We direct your attention to AMINOPHYLLINE ENTERIC COATED B-M — valuable when the patient experiences gastric irritation from aminophylline.

*Coated under license from the State University of Iowa Research Foundation. U. S. Patent 2,373,763.

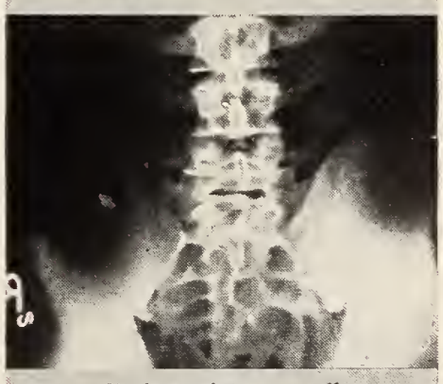
CLINICAL CONFIRMATION



Radiograph taken five minutes after intake of 6 tablets Enteric Coated B-M . . . all tablets are in stomach.



Four hours later . . . all tablets now in intestines.



Six hours later . . . all tablets disintegrated or in that process.

BARLOW-MANEY LABORATORIES, INC.
CEDAR RAPIDS, IOWA

Our Products Can Be Secured Through:
W. R. Brown Co., 1321 Delaware Ave., Detroit, Mich.
White & White Pharmacy, 128 E. Fulton St., Grand Rapids, Mich.
Cadillac Medical Supply Co., Cadillac, Mich.
G. A. Shaffer, 74 West Clark Ave., Coldwater, Mich.

TAKING CARE OF THEMSELVES

(Continued from Page 976)

1,300,000, of which 1,060,000 have the surgical care plan in addition to the hospital care plan.

This is not all, however, for the commercial insurance companies cover millions of other Americans.

A study prepared by the Institute of Life Insurance for the Life Insurance Association of America, shows that at the start of this year there were 225,950 employer units of group insurance of all kinds in force, providing 60,171,000 individual units of protection, and including 35,580 group accident and health weekly indemnity plans covering 8,377,000 workers, 27,750 group hospital expense plans protecting 7,110,000 workers and 7,080,000 of their dependents, 25,610 group surgical plans protecting 6,529,000 workers and 4,574,000 of their dependents, and 4,180 group medical expense plans with 852,000 workers and 246,000 dependents covered.

In addition, millions have other types of group insurance, to say nothing of the vast numbers with individual insurance of various kinds.

Tremendous gains in the numbers of all types of such policies are reported in the past year, by the Institute of Life Insurance, while the Blue Cross reports adding 23,000 persons every working day.

In the 1947 calendar year, more than $211,000,000 was paid in hospital bills for more than 3,500,000 Blue Cross subscribers.

America's answer to "socialized medicine" is implicit in the tremendous and unprecedented increase both in commercial coverage and in the Blue Cross plans sponsored by the hospitals, the medical profession and other agencies.

Americans, generally, prefer to spend their own money at their own option rather than turn it over to the Government, in taxes, to be sent back as bureaucrats may dictate.

—Editorial, *Grands Rapids Herald,* August, 1948.

DRAFT BOARDS AGAIN

With the passage of the first selective service legislation to operate in the United States in a time of putative world peace (the selective service bill of September 7, 1940, was signed by President Roosevelt, September 16, 1940, after the war in Europe was well under way, Poland having been invaded September 1, 1939), the physicians of this country will once again be called upon to implement the mechanism of the draft. Inductions will commence September 22 of this year, a date which precedes the start of the academic year of virtually all colleges. All men of the ages of eighteen to twenty-six must register, probably in the month of August.

Proposals to extend the draft for physicians and dentists to age forty-five were not passed. Yet there are few doctors available younger than twenty-six, and the draft contains provision stating that no person shall be inducted "until adequate provision" has been made for "medical care and hospital accommodations."

In this day and age of super speeds and elaboration of mechanisms of all kinds, the public is made aware of the perfection of things, devices, artifacts, structures. These things can be photographed, pictorialized, described. Especially with respect to medicine, there exists the tendency to overemphasize the importance of drugs, apparatus, buildings, and machinery and to minimize the essential—the doctor, the *deus ex machina,* who must prescribe intelligently, interpret the product of the apparatus knowingly, for instance, the x-ray film, and make the machinery of the draft of any value.

Once again the doctors of the nation are to be called upon, far in advance of the date inductions will start, to provide that expert knowledge and skilled medical service without which recruitment for the National Guard and the processing of selectees for the armed forces would be useless. Technical personnel can take x-ray pictures, electrocardiograms, give enemas and hypodermic injections, make electroencephalograms, operate diathermy machines, and do laboratory procedures, but, to interpret all these things in terms of health or morbidity, there is no substitute for the doctor, and the better trained and more experienced the doctor, the better it will be for all concerned.

We hope that this will be emphasized in the new selective service program and be brought home to the families of the nation.

—Editorial, *New York State Journal of Medicine,* August 1, 1948.

BLUE CROSS

Evidence that Blue Cross is one of the significant social developments of the twentieth century is provided in the fact that, with over 31,000,000 members, it has enrolled more participants in less time than any voluntary movement in the history of the world.

for liver damage **MEONINE®**

(dl-methionine Wyeth)

IMPORTANT WYETH ADDITION TO

New and Nonofficial Remedies

Realizing that traditional management of severe liver disease has been on the whole disheartening, Wyeth has for years been conducting research on the essential amino acid most concerned with liver function . . . dl-methionine.

Product of this research is Meonine.

Meonine may be used to supplement the protein-rich diet usually prescribed whenever the liver has been damaged by malnutrition, alcoholism, pregnancy, allergy, or toxins. And it is clearly indicated if this diet cannot be taken. There is no evidence, however, that Meonine is more effective than foodstuffs such as casein and egg white which contain pure methionine.

In early stages of cirrhosis, clinical results with Meonine have been most encouraging. Complete directions for use and bibliography supplied on request.



Meonine supplied in 0.5 gram tablets, bottles of 100 and 1000. Crystalline Meonine—for preparing injection solutions—supplied in 50 gram bottles.

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Michigan Medical Service

Michigan Medical Service Payments

The statement has been made that because of the low ceiling MMS payments have become virtually an indemnity. A study of the charges and payments in one of our counties shows that the fee schedule pays 67.3 per cent of all charges.

Service Audit Cards

During the period from October 15, 1947, to June 30, 1948, Michigan Medical Service has mailed to its subscribers, who have had services rendered, 4,390 cards of enquiry. Of these, 1,348 (30 per cent) were returned; 1,212 (89.91 per cent) were entirely satisfied; 107 (7.9 per cent) were not entirely satisfied, and twenty-nine (2.15 per cent) made enquiries. Of the complaints, eighty-eight were for MMS and nineteen for MHS. The medical complaints (sixty) were that the surgical benefits were not adequate, did not cover the whole bill; ten said the x-ray benefits were not adequate. Two complained that consultation service was not included; four objected to the payments being directly to the doctor; four said the doctors' payments were delayed too long; one wanted the office visit prior to surgery included; two were not satisfied with the service of the doctor, and the balance were miscellaneous. Hospital service complaints were that three had to accept ward services instead of semi-private, and twelve were about less benefits in non-participating hospitals. That seems to be a very good average, but it is hoped that future surveys will not show any dissatisfied with the doctor's services.

Living Costs

The June, 1948, *Monthly Labor Review* (Federal) shows the cost of living 168.8 per cent, with the 1935-39 level fixed at 100. In 1946, this figure was 139.3, and in 1947, it was 159.2. The Commissioner of Labor in Michigan in 1941 reported 88 per cent of families earning under $3,000; in 1946, 36 per cent of the families were under $3,000.

Paid Services

Up to June 30, 1948, there had been paid to doctors for services $26,811,712.08 and for veterans $2,067,155.25, making a grand total of $28,878,867.33. All claims are paid or a reserve set up for payment. There is a reserve for contingencies of $1,685,649.70.

Utilization

Reports show that in the first five months of 1948, out of 1,000 Blue Cross certificate holders in Detroit 129 were hospitalized each month; in New York, 99; in Boston, 128; all plans 126. The stay in the hospital in Detroit was 8.18 days.

Ford Motor Company

Blue Cross enrollment of Ford Motor Company employes and their dependents will be undertaken this fall. The Ford workers will be enrolled in Michigan's Blue Cross Plans, Michigan Medical Service and Michigan Hospital Service, and in thirty other Blue Cross plans throughout the country.

THE INDUSTRIAL PHYSICIAN AND CANCER

(Continued from Page 972)

his views on industrial health and safety, articles on cancer and other nonindustrial illnesses should be included. A close liaison should be maintained with the supervisory personnel. A reliable, congenial employe who develops personality difficulties should be investigated by the medical department. An unsuspected organic disturbance, such as a cancer, may be the reason for the change in personality. Too much emphasis cannot be placed on frequent consultation by the middle-aged person with his doctor. The industrial physician must grasp his multiple opportunities to aid in the early diagnosis of cancer.

Pigmented moles should be removed before puberty because they become malignant only after puberty.

* * *

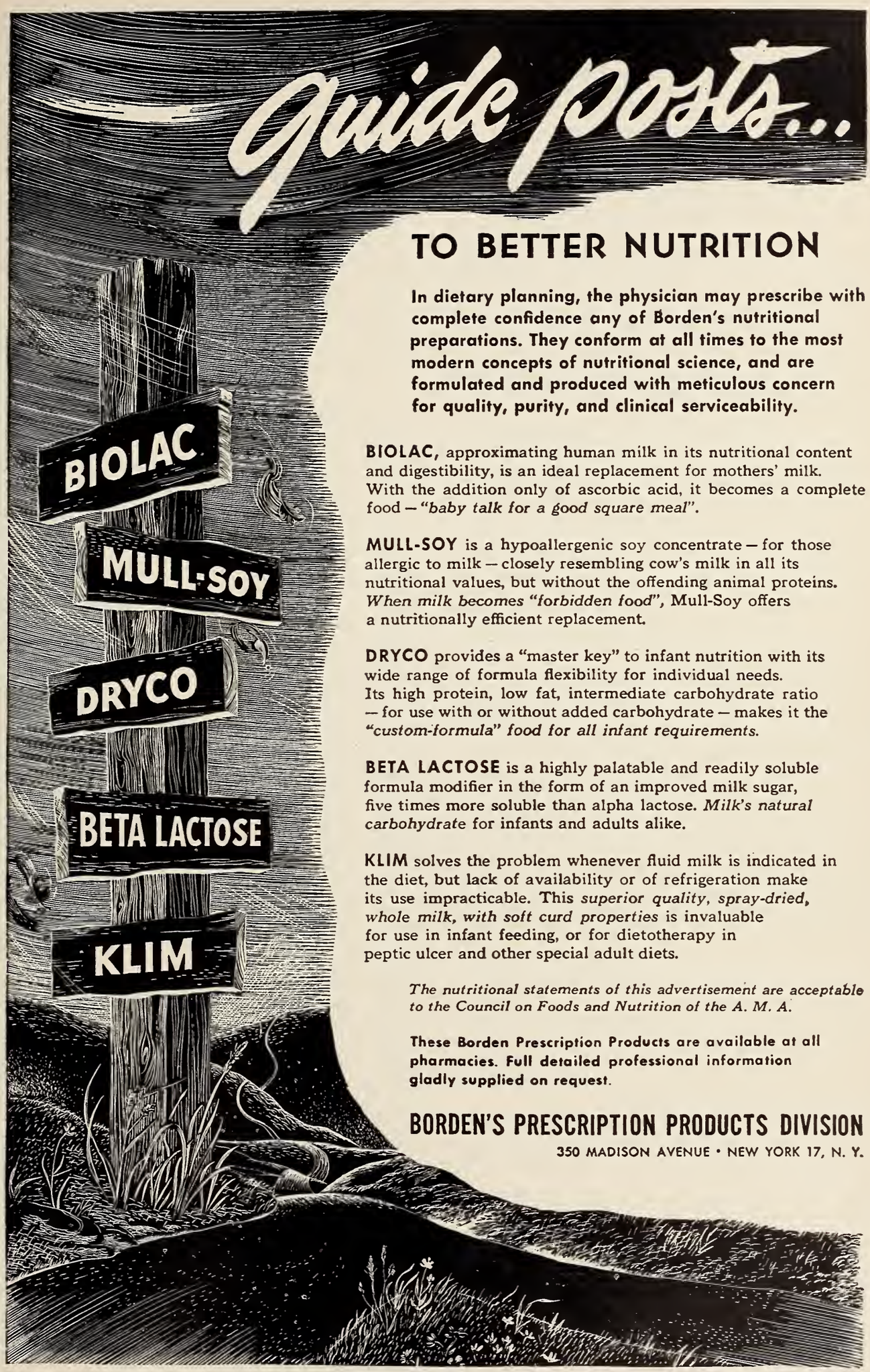
Loss of appetite for meat may indicate a malignancy other than in the gastrointestinal tract. Anorexia may be part of the mental depression which accompanies carcinoma anywhere in the body.

* * *

Digital examination of the rectum for carcinoma gives more information when the patient is in the lithotomy position.

* * *

The spinster is more likely to have carcinoma of the breast than a mother.



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Beaumont Memorial at Mackinac Island

Final action on plans for the establishment of a medical shrine on the Mackinac Island site where Dr. William Beaumont began his world-famous physiological experiments in 1822 are expected to be taken when the Michigan State Medical Society meets in Detroit, September 20-24.

At the July 24 meeting of The Council, W. F. Doyle, member of the Mackinac Island State Park Commission, outlined a program for the raising of $30,000 from Medical Society members and the general public for restoration of the old retail store of the American Fur Company. It was here where the young fur trader, Alexis St. Martin, was accidentally shot through the stomach, opening a "window" through which Dr. Beaumont made his observations on digestive processes.

Mr. Doyle was introduced by O. O. Beck, M.D., of Birmingham, chairman of The Council. The Island commissioner traced the history of the purchase of the building with funds provided by Parke, Davis & Company in 1942, and pointed out that research work accomplished by Prof. Emil Lorch of the University of Michigan college of architecture in co-operation with Fred A. Coller, M.D., of Ann Arbor, is now complete.

"Tentative plans and specifications have been drawn and work is ready to begin on the actual restoration work," Commissioner Doyle said. "When rebuilding and landscaping is complete, this fine old structure at the foot of old Fort Mackinac will be a shrine to the medical profession of not only Michigan but the entire world."

Following Mr. Doyle's talk, The Council unanimously adopted a resolution requesting Dr. Coller, as chairman of the MSMS Beaumont Memorial Committee, to make final recommendations which will be passed on to the House of Delegates at its September meeting.

The restoration itself will be under the direction of Mackinac Island State Park commissioners W. F. Doyle, Louis P. Simon, of Kalamazoo, and Joseph H. Thompson, of Ypsilanti.

Governor Kim Sigler has consented to act as honorary chairman of a "Committee for Restoration of the Beaumont Medical Shrine" and has offered his wholehearted endorsement to the project.

"I am deeply impressed with plans being made for the restoration of this building," he said. "Not only will the people of Michigan appreciate these efforts, but especially should the medical profession of our state and nation be proud of this magnificent gesture to hold out to the world the unparalleled achievements of one of its illustrious members."

State Treasurer D. Hale Brake has agreed to serve on the committee as trustee of all funds collected.

MICHIGAN MEDICAL SERVICE ANNOUNCES IMPORTANT CHANGES

Dr. R. L. Novy, President of Michigan Medical Service, announced in his recent letter important changes in policy and the availability of simplified forms:

(1) Effective September 1, 1948, the Board of Directors authorized payment of fees under all Michigan Medical Service certificates for services rendered to subscriber-patients in the doctors' offices or in the outpatient department of a regularly accredited hospital where the fee in accordance with the Michigan Medical Service Schedule of Benefits for such surgical procedure is $20.00 or more. If x-ray services are rendered in the office and related surgery follows within thirty days in the office, the x-ray fee will be paid as well as the fee for anesthesia if rendered by a doctor other than the doctor in charge of the case. All subscribers have been sent a copy of "Office Surgery Liberalization" for attachment to their certificate.

Dr. Novy called to the attention of other doctors that on September 1, 1947, the Board had approved as an experiment this same type of liberalization under the medical-surgical certificate only. The experiment proved successful, and the early fears of excess utilization proved unwarranted. Now with this new change, all Michigan Medical Service certificates provide for office and outpatient department surgery in accordance with the conditions outlined above.

(2) It was announced that effective October 1, 1948, a new method of paying doctors for services rendered would be put into effect. Up to the present time, Michigan Medical Service has issued a check on each individual case. Under the new procedure, cases will be accumulated for each doctor and at the end of each ten-day period a check will be issued. All doctors received a specimen copy of the new check. This check makes it possible to list the names of eleven patients, claim numbers, the amount for services rendered and the total amount of the check. Fees for services rendered veterans will also be paid on this regular check. There is a special column headed "Veterans" and if the payment is for services rendered a veteran, an asterisk will be shown in that column. This new procedure is being handled by the use of International Business Machine punch cards and machines and will simplify the work of the doctors' secretaries and will make it more advantageous to the doctors' offices as well as Michigan Medical Service.

(3) Many requests have been received from doctors for literature to place in their offices which could be furnished patients who are interested in securing voluntary prepaid hospital-surgical-medical protection as recommended by the State Medical Society and the Hospital Association. A new form was devised for this purpose, which is called "Patient Inquiry Card." All doctors can secure a supply of these by writing the Detroit office.

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Roentgen Ray Treatment of Hemangiomata

By H. G. Sichler, M.D.

Lansing, Michigan



SOON AFTER the discovery of the x-ray by Roentgen in 1895, and of radium by the Curies in 1898, numerous observations were made by several dermatologists that the common types of nevi were quite sensitive to the newly discovered rays, and could be induced to undergo rapid involution by treating them with suitable doses of either the x-rays or the beta and gamma rays of radium.

At that time the generation of x-rays was very difficult and unreliable, depending upon discharges from condenser coils through a "gas" tube, and the use of any x-ray apparatus was accompanied by a considerable electrical hazard from the exposed high tension wires leading to the terminals of the open tube. In addition to this, the accurate measurement of x-ray dosage was not accomplished until 1928, when the present unit of measurement, the international "r" unit, was universally adopted as the standard for measurement of x-ray dosage. At about this same time, the general principle was finally established that, in equivalent doses, x-rays and the beta and gamma rays of radium have exactly the same effect on the tissues of the body.

It is historically interesting to note that the epilating effect of x-ray was first discovered by the Viennese physician, Freund,[5] in 1896, within a few months after the discovery of the x-rays, as an accidental result of the taking of x-ray plates of the head, which at that time required one full hour of x-ray exposure. This same Freund was also the first to utilize the epilating effect of x-rays in medical treatment, when he treated a large nevus pilosus (hairy mole) in 1896, and succeeded in removing not only the hair but most of the lesion, with only a small residual ulceration remaining, due to overdosage.

Under the circumstances of extreme technical difficulty, uncertainty of dose, and electrical hazards which generally prevailed in the use of x-rays for therapeutic purposes from 1900 to about 1920, it is not at all surprising that there developed among dermatologists and radiologists a distinct preference for the use of radium in the treatment of hemangiomata and associated lesions of the skin. The radium was used in the form of "plaques" or "screens," which consisted of a flat metallic silver plate of variable size, 1 to 4 cm. square, coated with a solution of radium salts and covered with enamel, varnish or monel metal, which absorbed the alpha rays, but allowed free emission of the beta and gamma rays. These plaques were applied to the lesion for variable periods of from ten to thirty minutes, depending on the dose desired and the amount of radium within the plaque. Later, this technique was changed to make use of gamma radiation from platinum filtered tubes, in which 5 or 10 mg. capsules were used, spaced at small equal intervals and applied with as close contact as possible. The reason for this form of treatment is not very clear, as a very penetrating radiation dose is produced which could severely affect the deeper tissues, and a less homogeneous dose is provided which may result in uneven involution of the nevus.[4]

With the development and widespread use of completely shockproof and self-contained x-ray

machines during the 1920's and 1930's, and the attainment of accurate measurement of the x-ray dose by the use of the international "r" unit, it was gradually found to be much more accurate, simpler and effective, to treat these angiomatous lesions with x-rays rather than with radium, because the necessary radiation dose can be given with much more accuracy and precision. The dose obtained is also much more homogeneous and can be given in two to five minutes with the output available from most x-ray therapy machines, as contrasted with treatment times of ten to thirty minutes with radium plaques or tubes.

Clinically the hemangiomata are divided into four main types:

1. Capillary hemangioma, nevus flammeus, or port-wine mark.
2. Hypertrophic hemangioma, nevus vasculosis, or strawberry birthmark.
3. Cavernous hemangioma.
4. Mixed combination of the cavernous and hypertrophic types.

The first of these types, the port-wine mark, is usually located on the face or neck, and is usually a dark bluish-red in color. It is never elevated above the skin surface, which is smooth over its entire extent. These port-wine marks do not respond to radiation therapy, either x-ray or radium, and treatment with these agents should not be attempted. They are preferably treated with repeated doses of ultra-violet rays, by means of which the outer layers to the dermis can be peeled off and the pigmentation thus gradually removed. If this form of treatment is not successful, plastic surgery may be resorted to, or the lesion may simply be covered with one of the commercial cosmetic coatings (covermark) which are available.

The second type, the hypertrophic hemangioma, or strawberry mark, is by far the most common type. These lesions are elevated above the skin surface, are bright red in color, and vary in size from a pinhead to several centimeters in diameter. They respond well to irradiation treatment because they are composed largely of radiosensitive endothelial cells. The moderate doses of 300 to 400 r are preferably given at intervals of two or three months, and in this way practically complete involution of these lesions can be obtained over periods of one and one-half to two years, with no danger of later scarring of the skin or other sequelae. The absorption of the lesions can, of course, be greatly hastened by using larger doses at more frequent intervals, but this is not generally advisable because of the danger of later skin changes, atrophy and telangiectasis, which may develop ten or twenty years later if large doses are used. The only exception to this rule is in the case of infected hemangiomata, in which case larger doses may be used, with caution, to shrink down the lesion more rapidly.

The third type, or cavernous hemangioma, involves the deeper subcutaneous blood vessels and contains large blood spaces. They have the appearance of soft bluish colored swellings under the skin, and often occur in combination with a hypertrophic strawberry nevus on the surface. These lesions are somewhat less sensitive to radiation than the surface variety, but they respond well if treated in essentially the same manner as the surface strawberry mark, with higher voltage and filtration so as to obtain better penetration of the subcutaneous tissues.

Lymphangiomata, composed of lymphatic spaces and vessels instead of blood vessels, are much less common, and are less radiosensitive than hemangiomata, but can usually be treated with good success in the same manner as cavernous angioma.

All of the various types of hemangiomata are most sensitive to radiation during the early months of infancy,[1,6] and treatment should, therefore, be begun during the second or third months, or at least before six months of age, whenever possible.

There are some definite dangers associated with the radiation treatment of nevi which should be known and stressed. Great caution must be used in treating lesions located over the epiphyses of the long bones,[2,3] as a delivered dose of 400 r to the epiphyseal plate will produce a delay in bone growth. Glandular structures are also easily damaged by x-rays, and excessive dosage to any skin area should be avoided, as skin atrophy ulceration or telangiectatic changes may develop, either within a few months or many years later. It should always be borne in mind that the objective of the treatment is to clear up the lesions with the greatest possible safety, and no chances should be taken of late skin changes or delayed bone growth developing later, simply to hasten the eradication of the growth.

During the six-year period from 1940 to 1947, 202 cases of hemangioma have been treated with

x-ray therapy. Of these, 129 (64 per cent) were of the hypertrophic strawberry type; forty-five (22 per cent) were the mixed cavernous type, and twenty-six (13 per cent) were the uncomplicated cavernous variety. There were two lymphangiomata (1 per cent).

The average number of treatments required for good resolution of the lesions was six, over a period averaging eighteen months, with variations from six months to thirty-six months. No definitely bad results have been encountered, except for sixteen cases in which treatment was discontinued by the parents before a satisfactory result had been obtained, due to an insufficient number of treatments. These should be classed as uncompleted cases, rather than as unsatisfactory end results. All the remaining cases had satisfactory clearing of the lesion, so far as is known. The uncertainty is due to the fact that in many instances the baby is not returned for further examination or treatment after the parents feel that a satisfactory result has been obtained.

Conclusion

The treatment of hemangiomata with roentgen rays is the most efficient and effective method of therapy which is now available, and is generally preferable to the use of filtered or unfiltered radium therapy for this purpose.

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MSMS

COMPULSORY INSURANCE

"Doctor, My Statistics Feel Funny" is the title of an article by Dr. Maurice Friedman in the *Nation's Business,* which probes into the real story behind selective service statistics as they reveal the nation's health. In the September issue of *Better Homes and Gardens,* Albert Deutsch says "yes" and Greer Williams says "no" to the query, "Will Compulsory Insurance Keep You Healthy?" Williams speaks of the "popular Blue Cross sponsored by hospitals."

Psychosomatic Aspects of Peptic Ulcer

By Louis A. Schwartz, M.D.
Detroit, Michigan

"All good and evil, whether in the body or in human nature, originates in the soul and overflows from thence —therefore if the body is to be well, you must begin by curing the soul—and the cure has to be effected by the use of certain charms, and these charms are fair words, and by them temperance is implanted in the soul; and, when temperance is there, health is steadily imparted to the whole body—Let no one persuade you to cure him until he has first given you his soul to be cured, for this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."—*Socrates.*



THE UNFORTUNATE circumstance of the rapid development of the psychosomatic approach has not led to acceptance by clinicians in general but primarily to psychiatrists interested in the genesis of certain physical phenomena or to philosophically minded physicians and surgeons. The concept of the essential unity of mind and body has not led to a synthesis of physician and psychiatrist at a higher level. Its adherents are unavoidably psychological in attitude and jargon, and are bracketed with the psychiatrists by the orthodox bulk of the profession. Too frequently psychoneurotics are persona non grata in medical practice. They tire and exhaust the general practitioner and are the stumbling-block of all specialists.

Discerning clinicians recognized the association of peptic ulcer symptoms with periods of emotional stress long before the concept of psychosomatic medicine evolved. It was well established that emotion interferes with normal digestive processes. Until comparatively recent times, it has been maintained that peptic ulcer is particularly susceptible to aggravation by emotional disturbances.

Bergman in 1913 proposed the theory that peptic ulcer is caused by an imbalance of the auto-

Presented at the Medical Staff Meeting, Harper Hospital, Detroit, November, 1947.
The author wishes to express appreciation to William Bachrach, M.D., of Los Angeles, California, for his able assistance in presentation of this paper.

nomic nervous system. The effects of this imbalance are manifested in the stomach by spasm, ischemia, damage to the mucous membrane, and peptic digestion of the devitalized area. The resulting acute lesion initiates further spasm, thus establishing a vicious cycle which leads to a chronic ulcer. According to Bergman and his disciples, the "spasmogenic" ulcer arising from a "vegetative disharmony" occurred in individuals of a "neurotic" disposition. Hence they introduced the term "neurotic duodenal ulcer." From this it was but a short step to the concept that "vegetative imbalance" may be psychically caused or conditioned. As the psychic factors in peptic ulcer have come to receive more and more attention, the latter point of view has been more and more widely espoused. In brief, we have moved through the period when psychic trauma was considered to affect adversely an existing ulcer to the present-day concept that psychic disturbances cause peptic ulcer.

As it stands today, the psychosomatic theory of the etiology of peptic ulcer is based on three main premises: (1) that most ulcer patients manifest a characteristic personality pattern or conflict-situation; (2) that this emotional status is accompanied by hypersecretion and hypermotility of the stomach, and (3) that hyperactivity of the stomach leads to peptic ulcer.

Since the elucidation of the ultimate cause of any disease holds the greatest promise for its effective control, the psychosomatic theory deserves the thoughtful consideration of everyone who is interested in the problem of peptic ulcer. It should not be embraced wholeheartedly on the one hand, nor rejected unreservedly on the other, without a critical evaluation. It is of utmost importance to re-examine the premises upon which the theory was evolved, and to review the experimental evidence which has been advanced to support it.

Alexander points out that the studies by internists and physiologists fall short of an accurate evaluation of the deeper psychological forces obtained in a given patient. This is, however, to be expected, since such studies require special training and experience. Furthermore, according to Alexander, not even a careful psychiatric anamnesis can be fully substituted for the analytic approach in uncovering the psychic factors causative of a somatic disturbance. It would appear then that in the interests of greatest accuracy, a review of the evidence for a common denominator of the emotional status of peptic ulcer patients should be conceived as only the work of specialists. There are three basic contributions to this orientation.

Chronic Fear, Suggested by Draper.—Considerable difficulty is encountered in following Draper's argument on the psychic pattern in peptic ulcer. In 1927, Draper and McGraw obtained evidence that in the psychological, as in the morphological panel of ulcer patients, maleness was the essential feature. Male members of the "ulcer race" were described as having strong heterosexual urge, whereas the masculine component in the female ulcer patient was expressed as a "diminished interest in erotic experience." These observations were considered to be consistent with the fact that the incidence of peptic ulcer is much higher in males, i.e., it is a male disease, or a disease of maleness.

In 1932, Draper and Touraine, influenced by Crile's report on the relation of hyperthyroidism and peptic ulcer, were compelled to reconsider the validity of their "male disease" thesis. Crile had pointed out that (1) the vegetative disturbance in exophthalmic goiter is similar to that in peptic ulcer patients, (2) hyperthyroidism was associated with hyperactivity of the stomach, and (3) five cases of peptic ulcer were apparently cured by partial thyroidectomy and left adrenalectomy. "In addition to these observations of Crile," Draper and Touraine continued, "it is commonly known that exophthalmic goiter and hyperthyroidism are from six to eight times more frequent in women than in men. . . . In view of these considerations, consequently, it would appear paradoxical that more men than women should be affected with ulcer. The only explanation for this paradox seemed to be in the fact of femaleness within the male."

Accordingly, the authors re-examined the literature and their own case histories and observations, and on deeper psychologic investigation they were able to identify a "masculine protest." "A man who possesses that degree of femaleness which threatens the authenticity of his essential maleness becomes subjected to deep-rooted, unconscious fears lest he fail in his attempt to play successfully the masculine role in life."

At any rate, in the most recent publication on this subject by Draper and his associates, it appears that "femaleness" or the "feminine component" is no longer considered to be the main feature, although it is still a factor. "Especially does it seem that unconscious awareness of the feminine component may be a stimulus to the overexploita-

tion of their virility which is so characteristic of ulcer bearers." The essential point in the psychic panel was "the fear emotion arising from various stimulating mechanisms."

Concerning the "persistent hold on mother principle and fear of loss of mother surrogate's approval," which appears to be the most consistent source of fear in the group studied, Draper et al write: "When you read the intimate histories of persons who have ulcers . . . the impression develops that these individuals, like frightened neglected children, are striving continually to recapture and maintain the mother principle which had ministered so meticulously to the demands of that delicate infant receptacle for milk." The next paragraph begins: "The more one observes these victims of chronic fear. . . ."

Thus, "fear," "fright," "frightened" are the words recurring throughout Draper's discussions of the psychic status of peptic ulcer patients, so we must presume that he considers chronic fear to be the dominant emotional force in these patients.

Repressed Oral-receptive Tendencies (Alexander).—Studies undertaken at the Chicago Institute for Psychoanalysis under the direction of Alexander have resulted in the formulation of a narrowly definitive hypothesis regarding the basic psychological personality problem in peptic ulcer patients. The program was guided by three assumptions:

1. The psychic factors causative of the somatic disturbance are of a specific nature.

2. Conscious psychologic processes play a subordinate role in the causation of somatic symptoms, since such conscious emotions and tendencies can be freely expressed and relieved through the voluntary system.

3. The patient's actual life situation has usually only a precipitating influence on the disturbance.

The author thus assumed, *a priori,* that there was to be sought in these patients not a distinctive personality pattern, but rather a typical conflict-situation, and the aim of his studies was to identify this conflict. The second assumption is a gratuitous one; certainly, conscious emotions can be expressed through the voluntary nervous system, but clinical observation has shown repeatedly that in many peptic ulcer patients the outward appearance of self-control is carefully maintained. The third assumption, namely, that the environmental circumstances are not the basic cause but only the precipitating factor, corresponds with the general clinical impression.

Alexander states that although certain personality types might be more likely to become involved in this conflict-situation, he has observed that in appropriate circumstances other types of character may develop the same conflict. He cites the case of a man who, unlike the usual ulcer patient, had little ambition, drive, or urge to excel. During many years of marriage with a woman who thwarted his receptive tendencies, he developed gastric symptoms and eventually a peptic ulcer. After a severe hemorrhage from the ulcer, he established relations with another woman of a motherly type, and all his symptoms disappeared.

Anxiety, Insecurity, Resentment, Guilt and Frustration.—The personality features and reactions of thirty patients with peptic ulcer were studied by Mittelmann and Wolff. They found a wide range of personality types which, however, shared a common and characteristic reaction pattern which consisted of intense anxiety, insecurity, resentment, guilt and frustration. Thirteen "normal" subjects were studied as controls, but the personality findings in the controls were not disclosed.

The Effect of Emotion on Gastric Secretion and Motility

The most obvious feature of the pathologic physiology of peptic ulcer is hyperactivity of the stomach in both its motor and secretory functions. One of the premises of the psychosomatic theory is that this hyperactivity can and does accompany emotional states or conflict-situations. Alexander envisions the relationship as follows: "If the intense wish to receive, to be loved, to depend upon others, is rejected by the adult ego and consequently cannot find gratification in normal life relations, then only the regressive pathway remains open; the wish to be loved becomes converted into the wish to be fed. The repressed longing to receive love and help mobilizes the innervations of the stomach, which are since the beginning of the extrauterine life closely associated with the most primordial form of receiving something, namely with the process of receiving food. These innervations serve as a chronic stimulus of the stomach and are independent of the normal organically conditioned stimulus, namely, the need of food; this stimulus

has its origin in emotional conflicts entirely independent of the physiologic state of hunger. Those individuals who on account of the described conflict-situation have to repress and abnegate their overstrung receptive cravings express them in the tacit physiological language of the stomach functions. Such a stomach behaves all the time as if it were taking or were about to take in food."

Mittelman and Wolff consider that an excessive secretion of the stomach under stress may be a manifestation of an attempt to resolve hostility and gain security through eating. The hypersecretion might, they suggest, represent preparation for eating the prey or enemy.

These hypotheses represent an important development in our concepts of the effect of emotions on digestive functions. They imply that certain displeasurable or dysphoric effective states cause an augmentation of gastric activity—a change hitherto considered to be associated only with pleasurable feelings.

Observations have been reported of changes in gastric secretion or motility, or both, under conditions of emotional stress, in animals and man.

Effects of Emotional Stress in Animals.—The extensive literature on this point will not be detailed here. Suffice it to say that, in every report available, it has been concluded that the only effect of dysphoric emotional states on the gastric function in animals is inhibition. Whether the emotion was one of fear, anger, or frustration, the effects have been the same, namely, a decrease in glandular and muscular activity of the stomach. However, it may be argued that one could hardly distinguish with any reliability what kind of emotion an animal was experiencing.

Effects of Emotional Stress in Man.—In reviewing the reports to those of Mittelmann and Wolff, we will consider the effects on secretion and motility separately, because the earlier studies did not investigate both simultaneously.

In regard to the effect of emotional stress on gastric secretion, Beaumont observed that fear and anger were among the factors associated with inhibition of gastric secretion. Hornberg, Bogen and Schrottenbach reported diminution in gastric secretion as a result of anger or vexation, each of these authors performing his experiments on subjects with fistulas who were under six years of age. Moreover, the emotional stress produced was not very strong or of long duration; it amounted to what we would describe as teasing, e.g., the child was shown food but was not permitted to eat it, or was deprived of a toy, or was made to cry by a pinch of the arm.

Mantelli stated that immediately after a severe psychic disturbance lasting up to three hours there is a marked inhibition of gastric secretion. No data were presented, and the nature of the psychic unheaval was not disclosed. Heyer purported to show that a brief (five minutes) period of emotion, euphoric or dysphoric, produced in hypnotized volunteers by suggestion (war experience, choking, winning a lottery, railroad accident, et cetera) resulted in a reduction of the secretory response to suggested food. The data given to illustrate the effects were chosen arbitrarily from all of the experiments; the total number of experiments is not mentioned however, so there is no way of knowing the frequency of the observed changes. It may be questioned whether a "suggested" meal provides a consistently dependable secretory test. For example, Heyer states, "Although the aspirations after a real test-breakfast still yield the previous normal values, the oft-repeated and in a true sense really deceptive suggestions appear no longer to have the proper effect on the amount of flow as also on the HCl concentration. We had to let go a great number of experimental subjects because the volume of juice and the free acid decreased progressively." If this be so, then one must be extremely circumspect indeed in interpreting data on the effects of "suggested" emotions on "suggested" meals.

Wittkower studied the effect of suggested emotion, partly under hypnosis and partly in the waking state, on the secretory response to a caffeine test drink. His results were summarized as follows:

1. Similar effective stimulations in a given subject cause similar changes.

2. Similar emotions cause various changes in different subjects.

3. Various emotions cause similar changes in the same subject.

Moreover, there are certain individuals who react with an increased acidity regardless of the emotional state; there are others who show decreased acidity regardless of the affective state;

and in other subjects the changes are manifest in the volume, without alteration of the acidity.

The painstaking investigations of Todd on the physiology of the human stomach stand as the turning point in the concept of the effects of emotion on gastric motility. Extensive radiographic observations on medical students enabled Todd to discern characteristic motility patterns for various affective states. He showed that sudden or transient dysphorias, such as mental shock, acute disappointment, fear, or depressing mental strain, are accompanied by decrease in gastric tonus and weak or absent peristalsis. On the other hand, he found that in the anxiety complex the stomach always manifested hyperactivity. He states: "Since there is no distinction in pattern between it and the hyperactivity which precedes pyloric or duodenal ulcer, precautions should be taken to determine its transient or quasipermanent form. . . . If the hyperactivity is still present some general advice is distinctly indicated."

In 1938, McGregor stated: "Enough evidence has now been produced to show that gastric peristalsis and secretion are arrested in man not only by worry, anxiety, fright, fear and the major affective states, but also by much finer shades of feeling." However, from the reports as we have summarized them, we would conclude that prior to 1938 there was suggestive evidence that gastric secretion may be increased, and good evidence (Todd et al) that motility may be augmented, in emotional states. The recent work of Mittelman and Wolff appears to demonstrate conclusively for the first time a simultaneous augmentation of acid-pepsin secretion and motor activity of the stomach accompanying certain effective reactions:

The Relation of Hypermotility and Hypersecretion to Peptic Ulcer

It has not yet been settled whether hyperactivity of the stomach is a cause of peptic ulcer, or whether it is a secondary effect. All observers are agreed that excessive secretion *per se* cannot be the sole cause; a constitutional substrate or "diathesis" or predisposition appears to be a required factor. This conclusion is based on numerous observations in animals and man.

In regard to hypersecretion and peptic ulcer in experimental animals, one of the approaches to this problem was based on Pavlov's demonstration that if a pain stimulus be associated with the giving of food, the usual inhibitory effect of the pain on salivary secretion eventually disappears, and the pain stimulus may even become a conditioned excitor of salivary secretions. Pavlov's interpretation of this phenomenon was: "The stimulation which entered into the center for defense reaction now passes over to the food center" and that "there is merely a transference, an alteration of direction, and an attraction of energy from one center to another." It will be recognized that this is not essentially different from the psychoanalytic interpretation of the psychic origin of somatic symptoms, viz., that repressed emotional energy overflows into the vegetative centers.

The physiological anatomy upon which the concept of psychogenic stimulation of gastric secretion is based warrants consideration. That the vagus nerve carries excito-secretory impulses to the fundic glands of the stomach is a firmly established physiological fact. Because the cephalic phase of gastric secretion is mediated entirely by the vagus nerves, it has been tacitly assumed that the stimulation of gastric activity by emotional states also utilizes the vegal pathway. This assumption, although plausible and reasonable, awaits proof. Presuming that the vagus nerves are the nervous route for the transmission of these effects, we may now ask, how can affective states produce vagal stimulation? The excitation of the autonomic nervous systems which characteristically accompanies emotional reactions is considered to be due to stimulation of automonic centers located in the hypothalamus. The hypothalamic centers are under the control of higher centers in the thalmus and cortex. Thus, in the case of psychogenic stimulation of gastric secretion under conditions of emotional stress it may be presumed that the parasympathetic centers in the hypothalmus are activated by impulses controlled by the thalamus and cortex.

The stimulation of gastric secretion by emotional states acting over the vagal pathway has often been termed a type of "psychic" secretion. Had this term not been applied already to another definite physiological phenomenon there would be no objection to such usage. However, inasmuch as another mechanism of secretion is frequently designated by this term, confusion and ambiguity result from applying it to the more recently described phenomenon. The term "psychic" secretion has become firmly rooted in physiological literature as a designation for the secretion of gas-

tric juice by the vagal reflex mechanism in which the sight or thought of food (in the presence of appetite) is the stimulus. This is the original sense in which the term was used by Pavlov. From a bibliographic standpoint there is no way of knowing, when a paper bears the term "psychic effects" in its title, whether it deals with "appetite" secretion or emotionally affected secretion.

After it had been demonstrated that gastric secretion in response to sham-feeding could occur in the absence of the cortex, Ivy proposed that the term "cephalic" phase of gastric secretion be used to designate secretion which occurred in response to stimuli acting in the region of the head. The latter term includes, then, the psychic and appetite secretion of Pavlov as well as any secretion which may occur when stimuli (food) act in the region of the head but in the absence of cortical participation.

The secretion of gastric juice in response to emotional stimuli might be placed in the category of the cephalic phase. However, this would not be advisable because the cephalic phase denotes the first part of the digestive period of secretion, whereas, so far as is known, the emotional stimuli are independent of food-taking or the conscious thought of food. Therefore, until more is known concerning the mechanism of the gastric secretory response to certain emotional stimuli, it is advisable that a separate, new concept should be considered, namely, of a gastric secretion which occurs as a result of certain affective states unrelated to the taking or thought of food, to distinguish it from (1) digestive period secretion which includes cephalic, gastric and intestinal phases, and (2) basal secretion, which occurs in the absence of any known endogenous or exogenous stimuli. The neglect of the psychosomatic components of the peptic ulcer syndrome may in part be responsible for its high incidence and the frequent failure of treatment.

MSMS

BROOKINGS INSTITUTE REPORT

"The Issue of Compulsory Health Insurance," the Brookings Institute report, comments favorably on Blue Cross and Blue Shield: "The United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country . . . and there is every reason to believe that these trends will continue unabated under our present system of medical care."

Short Transverse Incision for Congenital Pyloric Stenosis in Infants

By Earl G. Krieg, M.D.

Detroit, Michigan



WOUND DEHISCENCE is a serious problem associated with congenital pyloric stenosis. In the group of thirty-two babies upon which this paper is based, some degree of faulty healing of the postoperative wound was present in ten cases. In one case all of the tissue layers broke down on the third postoperative day. All cases received vigorous preoperative and postoperative supportive measures, which included blood transfusions, subcutaneous glucose, saline, distilled water, vitamins, including large doses of ascorbic acid, and early feeding.

The short incision of Amendola, modified by Hartzell for its use in cases of perforated peptic ulcer, is advocated because it offers additional safety for the baby.

The advantages of the transverse incision are as follows:

1. The wound is small.
2. The rectus muscle remains intact, and its contraction during crying and other forms of straining pulls the wound edges together.
3. The incision through the transversus aponeurosis is in the direction and pull of its fibres, which also tends to close the wound during straining.

The following technical considerations are important:

1. The skin incision is made at the level of, or just superior to, the liver border.
2. The transverse incision through the right anterior rectus sheath extends a short distance over the midline.
3. The rectus muscle is dissected from its compartment for at least 2 cm. above and below the level of the fascial incision. Care must be taken not to rupture the thin muscle.
4. The posterior rectus fascia is incised horizon-

tally beginning at least 0.5 cm. over the midline.

The following case report illustrates the several points made above.

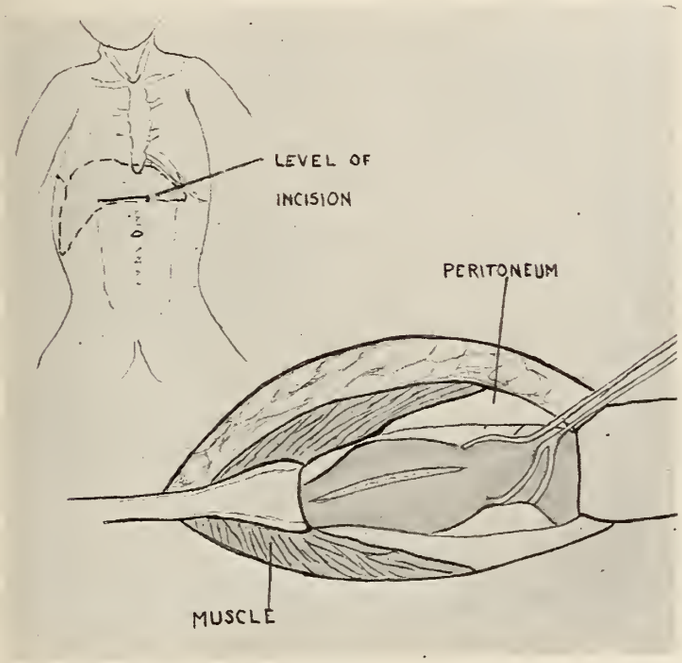


Fig. 1. Level of incision is shown in the upper left corner. The lower illustration shows the retracted rectus muscle and the incision through the posterior sheath.

Case Report

This case history is presented in collaboration with Dr. E. O. Jodar, pediatrician.

Wm. H., a first child, aged six weeks, had had normal delivery, weighing at birth 8 pounds 4 ounces. His admission weight was 8 pounds 2 ounces. There had been uneventful progress, with a one-pound gain in weight, until the fifth week, when he began to vomit. The vomiting was progressive in intensity and developed into the projectile type with visible peristalsis in the upper abdomen.

On March 18, 1945, he was hospitalized. The laboratory reported normal urine, Hemoglobin 9.1 gm., red blood cells 2,900,000, white blood cells 18,000, with 79 per cent polymorphonuclears. Subcutaneous saline was alternated with distilled water, 80 c.c. given three times daily. Subcutaneous vitamin C, 50 mg. daily, was administered, and he received a whole blood transfusion, 75 c.c., by Dr. Jodar. A temperature of 104° F. (rectal) receded to normal.

Operation was performed on March 20, using a short transverse incision, 2 inches in length, and doing the Ramstedt-Fredet procedure. A pyloric tumor was found which measured 1.5 cm. by 0.5 cm. in the thickness of the wall, and was very brittle. The stomach was dilated. Two hemostatic sutures were placed in the gastric wall. Abdominal closure was done in layers with "C" silk; intracutaneous chronic catgut was used for skin closure. Formula was given after four hours, and subcutaneous fluids (glucose, saline, distilled water, vitamin C) were given as above.

On the day after operation the temperature was 102° F. (rectal); there was some vomiting, but he retained most of his feedings. On March 22 the temperature was 101° F. (rectal). There was a gain in weight of 3½ ounces. A transfusion of whole blood was given by Dr. Jodar.

On March 23 the entire wound disrupted but without evisceration even after vigorous crying and straining. The skin separation was closed by an adhesive strapping. From March 24 to 29 there was progressively less vomiting; a septic type temperature was controlled by penicillin given for forty-eight hours. Subcutaneous fluids were stopped; another blood transfusion was given.

There was no vomiting on March 31. The weight was 8 pounds 4 ounces. The wound showed no evidence of healing. Hemoglobin was 10.2 gm., red blood cells 3,100,000, white blood cells 2,900, with 76 per cent polymorphonuclear cells. The patient was discharged to his home.

When the patient was seen at the office for redressing on April 2, little evidence of healing was noted. Formula was increased. On April 7 the wound showed evidence of granulation for the first time. The weight was 9 pounds. From April 14 to 28 the granulation was so exuberant as to require cauterization. The weight was 9 pounds 12 ounces.

The granulation was trimmed on May 7, and five days later the wound appeared solidly healed. The weight was 10 pounds 7 ounces. When seen on June 25, the abdominal wall was well healed, and there was no evidence of hernia. A year later, on June 15, 1947, the abdominal musculature was bilaterally equal in contour and function.

Comment

In the patient presented, after the wound disrupted on the third postoperative day, the physiology of the tissues about the wound was noted during crying and straining. The wound was kept closed by muscular action alone, which prevented evisceration for a period of two weeks, during which time no gross evidence of healing was present. The wound required five weeks to heal solidly. The final result was excellent.

1842 David Whitney Building
Detroit, Michigan

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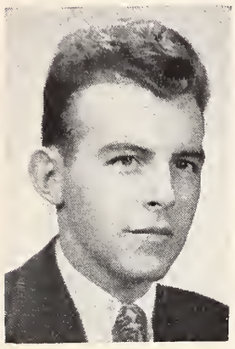
MSMS

MSNA

By request of many members of the Michigan State Nurses Association, Michigan Medical Service will offer an opportunity for their enrollment in its medical-surgical plan in October. The Blue Cross medical-surgical plan provides for payment for the doctor's services in hospital medical cases. The majority of MSNA members now enrolled in Blue Cross are protected only by the hospital-surgical plan.

Intraosseous Infusions in Infants

By E. Clinton Texter, M.D., and
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E. Clinton Texter

THE POSSIBILITY that the medullary cavity might be used as a route of parenteral fluid administration was suggested some years ago. In 1903, bone marrow punctures were done in laboratory animals,[63] and in 1910 marrow was obtained from the human tibia.[18] The trephine method of sternal biopsy[40,59] and the aspiration method[3] were reported. Subsequently the blood circulation of the sternum was examined and use of the sternum as a transfusion route was suggested.[12,14] When the availability of the intraosseous route was demonstrated,[6,7] reports of its use in clinical medicine soon followed.[8] Henning injected the sternum with iodipin, a contrast medium, and was able to demonstrate radiologically that the material rapidly left the sternum to enter the general circulation. He suggested that intrasternal transfusions might be a preferred method for administering fluids in emergency conditions. This has proved to be true.[13,25,31,32,43,54]

Tocantins and his associates deserve credit for stimulating interest in intraosseous infusion in this country. Some of his initial studies on the circulation of the marrow[51] and the determination of the circulation time[52] have been verified and extended.[35,41]

In 1941, Tocantins and O'Neill described their technique of intraosseous infusion and presented forty cases, to whom they gave fifty-two infusions. In a subsequent paper[56] they reported on fifty-six infusions given to forty-nine patients, with five failures. Most of the infusions consisted of whole blood, plasma, and fluids; however, other substances including anesthetic agents,[40,41] amino-acids,[1] penicillin[24,28] and a variety of solutions[4] have been given by this means.

A number of special needles have been described for use in intraosseous infusion.[4,19,22,29,30,31,39,41,51-57]

In 1943, Turkell and Bethell described a new needle for sternal biopsy, and later detailed its use for administration of fluids by the bone marrow.[58-61] In a previous paper[15] we have described our technique for transfusing infants using the Turkell needle. We feel that use of this method largely eliminates the dangers and complications, excluding sepsis, of this method.[15,36,39,40,44,47,48,53,55]

TABLE I

Number of Patients	*Number of Infusions*
44	1
30	2
24	3
8	4
7	5
6	6
4	7
2	9

TABLE II

Pneumonia	8
Erythroblastosis Fetalis	5
Congenital Diseases	5
Diarrhea of the Newborn	3
Hemorrhagic Conditions	2
Peritonitis	2

Tocantins first used the intraosseous route for infusions in children and utilized the lower third of the femur and the upper third of the tibia.[56] As has been repeatedly stressed, the sternum should not be used in children under the age of five, due to its thinness and relative state of underdevelopment.

Of the initial eleven infants reported by Tocantins, nine were successfully infused, with two failures. Subsequently this group[57] gave seventy-nine infusions to fifty-two infants, with three additional failures. Meola treated 144 infants with 326 infusions, listing one complication, while Behr administered sixty infusions, again with one complication. Arbeiter and Greengard attempted forty-three infusions, with thirty-five successes and eight failures, and Gunz and Dean reported thirty-five infusions with three complications. Others have stressed the advantages and indications of this method of treatment in pediatrics.[10,42,46] Recently Heinild and his associates have published the results of a co-operative study done in Denmark, where they treated 495 infants. Of the 1,000 infusions attempted, only eighteen were failures and only five complications developed.

Our report is based on a study of 125 infants treated by intraosseous infusion during the period of July, 1945, to June, 1947. Of these patients, we were able to successfully transfuse 124. In this

(Turn to Page 1005)

From the Departments of Pediatrics and Pathology, Providence Hospital, Detroit, Michigan.

TABLE III. SUMMARY OF PATIENTS WHO HAD INTRAOSSEOUS INFUSION
(125 Cases)

Case Number		Method of Infusion	Fluids Infused		Total number of c.c. infused	Total number of infusions	Number of Taps		
							Total	Successful	Failures
1	Erythroblastosis fetalis	D	Whole blood		50	1	1	1	0
2	Erythroblastosis fetalis	D	Whole blood		375	5	6	4	2
3	Erythroblastosis fetalis	D	Whole blood		190	5	5	5	0
4	Erythroblastosis fetalis*	D	Whole blood		145	3	3	3	0
5	Erythroblastosis fetalis	D	Whole blood		330	6	5	5	0
6	Toxic bone marrow depression	D	Whole blood		100	2	2	2	0
7	Lymphatic Leukemia	D	Whole blood		25	1	1	1	0
8	Bronchopneumonia	D	Plasma		80	1	1	1	0
9	Chronic interstitial pneumonia*	D	Whole blood		190	2	2	2	0
10	Hypoplasia of bile ducts*	D	Whole blood		40	1	1	1	0
11	Erythroblastosis fetalis*	D	Whole blood		30	1	1	1	0
12	Erythroblastosis fetalis, necrosis right lobe of liver*	D	Whole blood		58	1	1	1	0
13	Premature, intracranial hemorrhage*	D	Whole blood		45	1	3	1	2
14	Severe burns, peritonitis*	D	Whole blood		370	4	5	4	1
15	Generalized spasticity	D	Whole blood		125	3	4	3	1
16	Neonatal diarrhea	D	Plasma	50	138	2	1	1	0
			10% Glucose in D. W.	88					
17	Neonatal diarrhea, anemia, eczema		None		0	0	2	0	2
18	Bronchopneumonia		Whole blood		55	1	1	1	0
19	Erythroblastosis fetalis, melena	D	Whole blood		210	3	3	3	0
20	Erythroblastosis fetalis	D	Whole blood		235	6	9	6	3
21	Celiac disease, toxic bone marrow depression	D	Whole blood		455	8	9	8	1
22	Neonatal diarrhea	D	Whole blood		50	1	1	1	0
23	Intussusception, surgical release	D	Whole blood		150	1	1	1	0
24	Neonatal diarrhea, premature	D	Whole blood, Hartmann's solution		600	6	6	6	0
25	Neonatal diarrhea, marasmus, pneumonia with lung abscesses*	B	Whole blood, Hartmann's solution 5 and 10% glucose in N.S.		3315	7	7	7	0
26	Neonatal diarrhea	D	Whole blood		50	1	1	1	0
27	Neonatal diarrhea, meningismus	B	Whole blood	220	1150	9	3	3	0
			Plasma	160					
			5% glucose in N. S.	160					
			Hartmann's solution	610					
28	Neonatal diarrhea*	B	Whole blood	170	320	4	4	4	0
			5% glucose in N. S.	100					
			Hartmann's solution	50					
29	Pneumonia, anemia	D	Whole blood	50	75	1	1	1	0
			Normal saline	25					
30	Neonatal diarrhea	D	Whole blood		40	1	1	1	0
31	Premature, vomiting	D	Whole blood		60	3	5	2	3
32	Erythroblastosis fetalis	D	Whole blood		120	3	4	3	1
33	Neonatal diarrhea	B	Plasma	120	260	3	2	2	0
			5% glucose in D. W.	20					
			Normal saline	120					
34	Neonatal diarrhea	B	Whole blood	50	325	2	1	1	0
			5% glucose in N. S.	275					
35	Intestinal obstruction	D	Whole blood	35	50	2	1	1	0
			5% glucose in D. W.	15					
36	Postoperative cleft palate, asphyxia due to aspirated blood, pseudohemophilia*	D	Whole blood		75	2	1	1	0
37	Bronchopneumonia with diarrhea	B	5% glucose in D. W., penicillin	500	575	2	2	2	0
			Whole blood	75					
38	Polyavitaminosis, feeding problem	D	Whole blood	185	260	5	3	3	0
			Normal saline	75					
39	Bronchopneumonia recurrent, mongolism*	D	Whole blood	200	275	7	4	4	0
			Normal saline	75					
40	Intracranial hemorrhage, newborn	D	Whole blood	140	190	4	6	3	3
			Normal saline	50					
41	Pyloric stenosis, pyloroplasty, aspiration pneumonia*	B	Whole blood	100	635	4	2	2	0
			Plasma	35					
			5% glucose in D. W.	500					
42	Atresia of esophagus, surgical anastomosis, atelectasis and mediastinitis*	B	Whole blood, Plasma, 5% glucose in N.S. 10% glucose in D.W., Adrenal cortical ext.		415	9	6	6	0
43	Neonatal diarrhea, chronic interstitial pneumonia*	B	Plasma, 5% glucose in D.W. Penicillin in N. S.		1690	15	2	2	0
44	Idiopathic bleeding, recurrent	D	Whole blood	480	540	4	2	2	0
			Normal saline	60					
45	Intussusception, surgical release, atelectasis, ileus and peritonitis*	B	Whole blood	75	305	5	1	1	0
			Plasma	200					
			Normal saline	25					
			Adrenal cortical ext.	5					
46	Premature, generalized edema	D	Whole blood		30	1	1	1	0
47	Neonatal diarrhea	D	Whole blood	15	25	2	1	1	0
			Normal saline	10					
48	Ventricular septal defect, toxic bone marrow depression, chronic interstitial pneumonia*	B	Whole blood	275	1430	10	3	3	0
			Plasma	75					
			5% glucose in N. S.	1000					
			Normal saline	80					
49	Neonatal diarrhea, anemia	B	Whole blood	240	740	4	2	2	0
			5% glucose in N. S.	500					
50	Intussusception, shock, surgical release	B	Plasma	100	1100	2	1	1	0
			5% glucose in D. W.	1000					
51	Erythroblastosis fetalis	D	Whole blood		150	2	2	2	0
52	Newborn, cyanosis, anemia	D	Whole blood		50	1	1	1	0
53	Erythroblastosis fetalis	D	Whole blood		380	7	5	5	0
54	Iron deficiency anemia	D	Whole blood		415	5	2	2	0
55	Erythroblastosis fetalis	D	Whole blood		235	4	4	4	0

TABLE III. SUMMARY OF PATIENTS WHO HAD INTRAOSSEOUS INFUSION
(Continued)

Case Number		Method of Infusion	Fluids Infused		Total number of c.c. infused	Total number of infusions	Number of Taps		
							Total	Successful	Failures
56	Pyloric stenosis, pyloroplasty	B	Whole blood	75	675	2	1	1	0
			5% glucose in D. W.	600					
57	Neonatal diarrhea, sclerema	B	Whole blood	100	1175	4	1	1	0
			Plasma	75					
			5% glucose in D. W.	500					
			5% glucose in N. S.	500					
58	Erythroblastosis, bronchopneumonia, bilateral*	D	Whole blood		35	1	1	1	0
59	Premature, bronchopneumonia, megaloblastic anemia	D	Whole blood		195	5	7	5	2
60	Pyloric stenosis, pyloroplasty, extreme malnutrition	B	Whole blood	130	3760	7	5	5	0
			Plasma	130					
			5% glucose in D. W.	1400					
			5% glucose in N. S.	1100					
			Amigen	1000					
61	Neonatal diarrhea, anemia	B	Whole blood	30	1880	5	2	2	0
			5% glucose in D. W.	1100					
			Darrow's solution	75					
62	Neonatal diarrhea, anemia	B	Whole blood	50	1250	3	1	1	0
			5% glucose in N. S.	1000					
			Darrow's Solution	200					
63	Erythroblastosis fetalis	D	Whole blood		160	3	3	3	0
64	Umbilical cord hemorrhage, shock	D	Whole blood		120	1	2	2	0
65	Neonatal diarrhea, anemia	B	Whole blood	435	1075	8	5	5	0
			Darrow's solution	600					
			Normal saline	40					
66	Neonatal diarrhea, anemia	B	Whole blood	275	675	6	3	3	0
			Darrow's solution	100					
			Normal saline	50					
			5% glucose in D. W.	250					
67	Premature, intracranial hemorrhage	D	Whole blood		30	1	1	1	0
68	Pyloric stenosis, pyloroplasty	D	Whole blood		85	2	2	2	0
69	Pyloric stenosis, pyloroplasty	D	Whole blood		110	2	2	2	0
70	Pyloric stenosis, pyloroplasty, diarrhea, aspiration pneumonia*	B	Whole blood	420	1320	7	4	4	0
			Normal saline	25					
			5% glucose in N.S. with parenamine	875					
71	Erythroblastosis fetalis	D	Whole blood		233	5	3	3	0
72	Cystic hydroma of neck, resection, asphyxia with paratracheal edema*	D	Whole blood		275	1	1	1	0
73	Iron deficiency anemia	D	Whole blood		285	2	3	2	1
74	Erythroblastosis fetalis, atelectasis both lower lobes*	D	Whole blood		110	2	3	3	0
75	Neonatal diarrhea, anemia	D	Whole blood		254	3	3	3	0
76	Neonatal diarrhea	D	Whole blood	85	165	2	2	2	0
			Plasma	80					
77	Neonatal diarrhea, anemia, bronchopneumonia	B	Whole blood	190	1190	4	3	3	0
			5% glucose in N. S.	1000					
78	Neonatal diarrhea	D	Whole blood		90	1	1	1	0
79	Pyloric stenosis, pyloroplasty, evisceration with secondary closure	D	Whole blood		270	3	3	3	0
80	Neonatal diarrhea, anemia	D	Whole blood	275	345	4	4	4	0
			Plasma	70					
81	Neonatal diarrhea, anemia	D	Whole blood		210	2	2	2	0
82	Pyloric stenosis, pyloroplasty, extreme emaciation	B	Whole blood	170	695	6	3	3	0
			5% glucose in D. W.	40					
			5% glucose in D.W. with parenamine	300					
			Plasma	185					
83	Umbilical cord hemorrhage	D	Whole blood		70	1	1	1	0
84	Neonatal diarrhea, anemia	D	Whole blood	70	180	2	2	2	0
			Plasma	110					
85	Neonatal diarrhea, anemia, pyoderm	D	Whole blood		310	4	4	4	0
86	Juvenile xanthomata, endocardial sclerosis with cardiac failure*	B	Whole blood	235	1435	7	3	3	0
			10% glucose in D. W. with parenamine	1200					
87	Pyloric stenosis, pyloroplasty, bronchopneumonia	D	Whole blood		55	1	1	1	0
88	Erythroblastosis fetalis, megaloblastic anemia	D	Whole blood		196	6	6	6	0
89	Neonatal diarrhea, anemia	D	Whole blood		100	1	1	1	0
90	Neonatal diarrhea, bronchopneumonia, torsion of spermatic cord, surgical release	D	Whole blood		210	3	3	3	0
91	Birth injury, torticollis, diarrhea	D	Whole blood		125	2	2	2	0
92	Neonatal diarrhea, anemia	B	Whole blood	240	560	6	6	6	0
			Plasma	120					
			10% glucose in D. W. with parenamine	300					
93	Aspiration pneumonia, toxic bone marrow depression	D	Whole blood		50	1	1	1	0
94	Premature, bronchopneumonia*	D	Whole blood		50	1	1	1	0
95	Neonatal diarrhea, anemia	D	Whole blood		180	1	1	1	0
96	Neonatal diarrhea, anemia	D	Whole blood		105	1	1	1	0
97	Neonatal diarrhea, anemia	D	Whole blood		50	1	1	1	0
98	Neonatal diarrhea, anemia	D	Whole blood		20	1	2	1	1
99	Neonatal diarrhea, anemia	D	Whole blood		125	2	2	2	0
100	Vascular occlusive disease, right forearm congenital, amputation	D	2½% ether in 5% glucose in D. W. with penicillin		800	2	1	1	0
101	Neonatal diarrhea, anemia	B	Whole blood	175	575	2	2	2	0
			5% glucose in D.W. with parenamine	400					
102	Premature, bronchopneumonia with atelectasis*	D	Whole blood		20	1	1	1	0

TABLE III. SUMMARY OF PATIENTS WHO HAD INTRAOSSEOUS INFUSION
(Continued)

Case Number		Method of Infusion	Fluids Infused	Total number of c.c. infused	Total number of infusions	Number of Taps		
						Total	Successful	Failures
103	Iron deficiency anemia	D	Whole blood	185	2	2	2	0
104	Bronchopneumonia, anemia	D	Whole blood	20	1	1	1	0
105	Erythroblastosis fetalis	D	Whole blood	352	7	7	7	0
106	Neonatal diarrhea, anemia	B	Whole blood 245 5% glucose in N. S. 500 5% glucose in D. W. with parenamine	1245	5	3	3	0
107	Neonatal diarrhea, anemia	D	Whole blood	100	2	2	2	0
108	Neonatal diarrhea, anemia, bronchopneumonia	B	Whole blood 150 5% glucose in N. S. 1000 10% glucose in D. W. with parenamine 200	1350	3	2	2	0
109	Neonatal diarrhea, anemia	D	Whole blood	45	1	1	1	0
110	Bronchopneumonia, anemia	D	Whole blood	300	3	3	3	0
111	Erythroblastosis fetalis, megaloblastic anemia	D	Whole blood	630	7	7	7	0
112	Bronchopneumonia, anemia	D	Whole blood	85	2	2	2	0
113	Bronchopneumonia, anemia, diarrhea	B	Whole blood 40 5% glucose in N. S. 190	230	3	2	2	0
114	Bronchopneumonia, anemia, diarrhea	D	Whole blood	75	1	1	1	0
115	Hemorrhagic shock	D	Whole blood	260	2	2	2	0
116	Erythroblastosis fetalis*	D	Whole blood	205	3	3	3	0
117	Normoblastic anemia	D	Whole blood	110	2	2	2	0
118	Intracranial hemorrhage	D	Whole blood	40	1	3	2	1
119	Pyloric stenosis, pyloroplasty, anemia	B	Whole blood 175 5% glucose in D. W. 200	375	4	3	3	0
120	Neonatal diarrhea	B	Whole blood 150 5% glucose in D. W. 500	650	2	1	1	0
121	Neonatal diarrhea, anemia	D	Whole blood	25	1	3	2	1
122	Neonatal diarrhea, anemia	B	Whole blood 215 5% glucose in N. S. 800	1015	5	3	3	0
123	Erythroblastosis fetalis	D	Whole blood	55	1	1	1	0
124	Malnutrition, iron deficiency anemia	D	Whole blood	135	2	2	2	0
125	Neonatal diarrhea, anemia	D	Whole blood	50	1	1	1	0
				48,740	383	325	300	25

D — direct or positive pressure transfusion.
C — continuous gravity drip infusion.
B — both direct and continuous infusion.

D. W. — distilled water.
N. S. — normal saline.
* — death.

group of patients, a total of 325 infusions was attempted, and, of these, 300 were successful.

The total number of infusions given was 383, and in three patients complications developed. These consisted of one case of subcutaneous abscess at the needle site (Case 25), and two cases of osteomyelitis (Cases 60 and 106).

Many patients were given multiple intraosseous infusions, as indicated in Table I.

The majority of infusions were given by positive pressure (ninety-one infants). This method was used mainly for blood, or when rapid administration was desired. In this method we use a 50 c.c. syringe, to which is fitted a three-direction valve, and two short lengths of rubber tubing. This is interposed between the transfusion bottle and the needle. The syringe is used both for withdrawing fluid from the bottle and injecting it into the patient. We feel that this method is superior to the two-syringe method used by Heinbild, and obviates the possibility of air embolism.[8,26] One patient received fluids by gravity drip alone, and in thirty-two infants both methods were used with success.

A variety of solutions has been given by the intraosseous route.[4,23,26,27,33,37,40,41,52,54,62] Most of our infants received blood, although other solutions were given, including the hypertonic potassium chloride, sodium chloride, sodium lactate solution, as advocated by Darrow[11,20] particularly in the treatment of neonatal diarrhea.

Twenty-five of the 125 infants in our series expired (20 per cent). In none of these cases could the cause of death be attributed to the use of intraosseous infusion. The causes of death are tabulated in Table II.

Various authors have listed the indications for intraosseous therapy. It is known that water and electrolyte balance are less precisely controlled in the infant than in the adult, and the water exchange of the infant per day is three to four times that of the adult.[17] Recently Darrow has shown that large amounts of potassium may be lost from

the intracellular compartment in such states of severe dehydration as infantile diarrhea. Replacement treatment is absolutely essential in these diseases, and clinical judgment, supplemented by the simpler laboratory tests and daily weight charts, has served as a guide to the type and amount of fluid necessary. We found intraosseous infusion particularly advantageous, when continuous treatment is indicated, as in the case of diarrhea or in the preoperative and postoperative care of an infant. Twenty of our patients had major surgical operations, and in three cases (Cases 42, 55, 72), continuous infusion was given during the course of the operation.

Tocantins has mentioned his difficulty in attempting to transfuse infants with erythroblastosis fetalis. Most of the failures reported have been in this group. In this group of patients the cortices were thicker and the bones seemed harder.[16] In spite of this, we were able to transfuse successfully the twenty infants with erythroblastosis in our series. This number included the more seriously ill infants encountered in 8,000 live births, during the period of this study. Of the twenty cases thus treated, fifteen are alive and well, a result which compares favorably with that reported by others.

As with any form of treatment, certain complications may develop. In our series we had three. The first infant had subcutaneous abscesses, while the other two developed osteomyelitis at the needle site. Both of the latter had clinical and roentgenologic evidence of complete healing following administration of penicillin.

As indicated in Table II, most of the deaths occurred in complicated cases. Only three deaths occurred in the neonatal diarrhea group, and none of these were during the second year of the study. We feel that the low mortality rate in this condition was largely due to the judicious use of blood and other solutions, particularly that solution recommended by Darrow.

Summary

In this report we have presented a study of 383 infusions given to 125 infants by the intraosseous route. Of the 125 cases there was only one in whom infusion was not successful. The clinical indications, complications, results of treatment and causes of death are included. When our results are added to those already presented, we believe that certain opinions can be expressed.

Intraosseous infusion forms a valuable adjunct to the pediatric armamentarium and should be given a wider trial.

The risk of producing osteomyelitis has been overemphasized in the past, and can be minimized with careful technique. Serial roentgenographic studies at the site of infusions did not reveal any significant or permanent changes, except in the two cases of osteomyelitis which occurred. In both of these, complete healing followed administration of penicillin.

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MSMS

Patients bedridden for a week may lose from 1 to 5 pounds because of muscle wasting due to inactivity.

* * *

Deficiency of blood proteins due to defective formation, as in liver disease, is not corrected by plasma or amino-acid mixtures.

* * *

The conjoint aim of medicine is to improve environment and to enable the individual to cope with it.

Michigan's Decentralized Resident Training Programs

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THIS IS IN the nature of a report to the profession of our state regarding the Decentralized Resident Training Program for Specialists which has been in operation for one and one-half years. It will also acquaint the profession with a new program for the training of general practitioners which is scheduled to start July 1, 1948.

With the increasing emphasis placed on certification by specialty boards, it became apparent several years ago that the number of medical graduates desiring training leading towards certification could not be trained by the existing number of approved residencies. It also became apparent that if residents were to prepare themselves properly for the specialty examinations they should have the opportunity to continue their study in the basic sciences along with their clinical training. Some twelve years ago the medical faculty of the University of Michigan had foreseen the need of making the educational resources of the Medical School available in much larger measure to hospitals throughout the state. However, various circumstances and later World War II prevented the formation of a program. This need was emphasized by a large number of returning veterans who, because of the emphasis placed on specialty training during the war, were demanding increased numbers of approved residencies.

After the cessation of hostilities, a grant was obtained from the W. K. Kellogg Foundation for the specific purpose of experimenting with the idea of decentralizing the influence of the Medical School and bringing this influence into as many hospitals as possible. This grant made it possible for the Medical School to obtain a co-ordinator, to enlarge its basic science faculty and to offer at

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the University a program of training and review courses to meet the needs of returning veterans as well as to start its Decentralized Resident Training Program. Some of the objectives of the resident training program were to provide more and better specialists and day-by-day continuous education for physicians through the medium of regional and community hospital teaching services, including ward rounds, staff meetings, and clinical-pathological conferences. One of its prime purposes has been to improve the quality of medical care for the people of our state. This project fits into the Michigan plan for an integrated system of hospitals[1] and should be an important factor in its success and development. The program for decentralized resident training has been described in detail,[2,3,4] and at this time it hardly seems proper to more than review the aims of the program.

It was realized that no static plan was likely to succeed, and rather than start with a plan that was not flexible, it was thought best to have a program that could, within rather wide limits, be changed as its faults became apparent or as the need varied. There were, however, certain broad principles which served to set the course of this program and which are believed to hold true in the continuous education of any physician.

1. Medical schools can no longer hope to prepare an individual for the practice of medicine for more than four or five years after graduation.
2. A physician can continue his own education, but this is not likely to be the most efficient method by which his skill can be maintained.
3. A medical school's primary obligation is to the undergraduate, but scarcely less important is its obligation of educating residents and practicing physicians.
4. This is especially true of tax-supported institutions in their relation to the practicing physician.
5. A medical school's influence should, wherever possible, be carried to the physician, as well as offering more formal training on the campus.
6. Short courses are valuable but do not obviate the need for planned day by day stimulation.
7. The best place for this day-by-day stimulation is in the hospital where the physician practices.
8. Ideally the practice of medicine should be made up of three components:
   (a) The care of the sick.
   (b) Teaching of undergraduates, residents, or other physicians.
   (c) Some type of investigative work.

A hospital that desires to affiliate approaches the university and states such a desire and is visited by the co-ordinator of the decentralized program. They are acquainted with the basic teaching requirements of the program which are:

1. Teaching ward rounds conducted daily.
2. X-ray conferences in each affiliated service weekly.
3. Clinical-pathological conferences which may alternate between medical and surgical cases weekly.
4. Clinical conferences by the medical service, and clinical and necropsy review conferences by the surgical services.
5. Responsibility during the surgical resident's fourth year for a fifteen- to twenty-bed ward or its equivalent.
6. Each chief of service must be either a diplomate or a fellow of his respective board or college. When this requirement cannot be fulfilled, a member of the staff with the above requirements may be selected from the service to act as preceptor.

In addition the university sends members of the senior faculty to the affiliated hospitals to participate in ward rounds and conferences once each month in medicine and surgery.

During the third year out of medical school, or the second year in specialty training, the resident comes from the affiliated hospital to the University of Michigan to spend either a year or nine months in the study of the basic sciences closely correlated with clinical application. During this period, approximately two-fifths of the resident's time is spent in clinical application while the remainder is spent in the basic science departments.

The basic science programs have been outlined with the primary objective of presenting them to physicians who have progressed to the point of resident in a specialty program. They are not merely reviews of sophomore courses, neither are they courses designed for graduate students; they are organized specifically for physicians who have reached a definite point in their educational development.

During the period of time from October, 1946, to October, 1947, there were thirty-two residents at the University of Michigan in the Basic Science Continuation Program from fifteen affiliated hospitals. Five of these men chose to spend twelve months while the remainder were in attendance for only nine months. Those who stayed for the extra three months had special clinical training or anatomical dissection. This year there are thirty-four residents from thirteen affiliated hospitals.

It has been gratifying to speak to residents who have returned to their home hospitals to finish their period of training, as well as to their superiors, and learn that in most instances all concerned feel that the year had been extremely worthwhile.

The basic science part of the program has been altered somewhat to meet criticisms from participants as well as faculty members, based on the experience of the first year. At the end of this year we intend to make what further alterations seem to be indicated and desirable.

The visiting program referred to above has been enlarged, and it is hoped that it will become a standard adjunct in the decentralization of resident training.

It is felt that through this affiliated program, some residencies, already excellent, have been improved, and it has made possible the approval of other residencies by the various certifying boards and bodies.

For some time it has been evident that there was need of a special program for the training of general practitioners. After consultation with many prominent practitioners throughout the state, the Council on Education and Hospitals of the American Medical Association and the Michigan State Board of Registration in Medicine, the following program was planned, and it is expected that it will go into operation July 1 of this year.[5]

Initially there will be two hospitals with which the university will affiliate for the training of general residents. There will be two interns and one general resident on duty at each hospital. In addition there will be two interns at the University Hospital for each of the two affiliated hospitals, making a total of four, who will after six months rotate with the two interns at the affiliated hospital. This will mean that eight interns during a period of one year will have six months training at the University Hospital and six months training at one of the affiliated hospitals.

ROTATION

First Year

University Hospital	Affiliated Hospital
2 months Med. wards 2 months Derm. O.P. 2 months Surg. O.P.	Will be divided into Med. (to include Ob.) and Surg. (to include Gyn.) services. The intern will spend 3 months on each service.

Second Year

University Hospital	Affiliated Hospital
2 months Neuropsych. O.P. 2 months Ped. 2 months Ob. and Gyn.	The gen. resident will spend 3 months on each service as during the preceding year but with increased responsibility.

Third Year (optional)

University Hospital
4 months Med. O.P.
4 months Surg. wards

The remaining 4 months will be spent under one of the board men in surgery at the affiliated hospital.

There will be a resident in internal medicine or a resident in surgery who will change every three to six months, so that over a period of a year there will be several men from the above-mentioned services at the University Hospital, rotating through the affiliated hospitals. These men will act as teaching residents, and will aid in the preparation of conferences, et cetera.

Each hospital affiliated will be expected to conform to all of the basic requirements asked for in affiliation in the present Decentralized Resident Training Program in the Specialties. This means that the following will be undertaken by each hospital:

1. A CPC once a week for nine months of the year which will alternate with medical and surgical cases.
2. An x-ray conference weekly for nine months of the year which will stress medicine rather than surgery but will contain some surgical cases.
3. A clinical conference once weekly that will stress diagnostic and therapeutic measures.
4. Each service will be headed by a diplomate of that respective board, or fellow of the respective college. When this requirement cannot be fulfilled, a member of the staff with the above requirements may be selected from the service to act as preceptor.
5. Teaching ward rounds will be conducted by the hospital visiting staff at least one hour five days each week.

The interns will be given a certificate by the University Hospital, and the second year will be recognized by a certificate from the University Hospital to the effect that the men have completed a year as "General Resident." During the time the interns are at the affiliated hospital, they will be paid by the affiliated hospital. This stipend is to be no less than that given by the University Hospital. Transportation to and from the University Hospital will be paid by the affiliated hospital.

The affiliated hospitals may expect one visit a month in medicine and one visit a month in surgery from members of the senior staff of the University Medical School. These visits will consist of a formal talk for one hour followed by consultations, rounds, et cetera.

In closing it would be wise to stress again that both of these programs are still considered experimental and are fluid enough to change as the need arises.

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Injury to the Brachial Plexus Associated with Labor and Delivery

Case Report

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Vermilion, South Dakota

THE PATIENT, Case No. 26,908, a married, forty-year-old, white female, entered the hospital on December 28, 1947, with a chief complaint of severe menorrhagia and metrorrhagia. Physical examination and laboratory examinations were essentially negative except the part to be given below. An x-ray of the cervical region revealed no cervical rib. The part of history relevant to the subject under consideration is as follows:

The patient's second child, a 7-pound 12-ounce healthy boy, was born on March 4, 1945. Preceding this delivery she was in labor six days. The details of the prolonged labor are not available, as it occurred elsewhere, but from the patient's description of it she was in a hospital, in hard labor, for six days prior to delivery. During this six-day period the patient, in association with her pains, did a great deal of pulling from the head of the bed. She was unconscious during delivery and does not recall what happened in the delivery room. On regaining consciousness she found that she was unable to flex the ring and little fingers of the right hand, and that the skin was anesthetic along the medial half of the right upper extremity, including the little and ring fingers. For several months postpartum she was unable to flex the right little and ring fingers. The patient's husband, a physiotherapist, has diligently treated the extremity since the onset of the injury.

The motor function to the little and ring fingers was gradually restored, but the area of anesthesia has persisted. During the past few months she has experienced a tingling sensation over the involved area of skin, indicative of a return of sensory perception.

Physical examination of the right upper extremity revealed that perception to pin prick was absent over the entire medial half of the limb, over the medial third of both surfaces of the hand, including the little finger and the medial half of the ring finger. The area of loss of perception to pressure was slightly less than that to pin prick. There was some ability to perceive heat and cold in the axilla and over the upper one-third of the medial aspect of the arm. There was no perceptible atrophy of the intrinsic muscles of the right hand, but abduction of the fingers was weak as compared to the left hand.

Dr. Reid is from the Goodrich General Hospital, and Dr. Summers is from the School of Medicine of the University of South Dakota.



Fig. 1. (*above*) The volar surface of the extremity. The area of skin showing loss of perception to pin prick was painted with a starch-iodine paste, appearing black in the photograph.

Fig. 2. (*below*) The dorsal aspect of the extremity. The black area represents the skin surface in which sensation to pin prick is absent.

It was concluded that the patient had sustained, at some time during labor or delivery, an injury to the medial cord of the brachial plexus from an upward pull of the arm.

Injury to the primary anterior rami of the eighth cervical and the first thoracic spinal nerves results in Klumpke's paralysis (also called Duchenne-Aran palsy). The medial cord, formed by the anterior primary rami of the eighth cervical and the first thoracic spinal nerves, gives off the medial brachial cutaneous nerve to the skin of the medial aspect of the arm (in association with the intercosto-brachial from the second thoracic spinal nerve), the medial antebrachial cutaneous nerve to the skin of the medial aspect of the forearm, the medial head of the median nerve (motor to the flexors of the fingers and the outer intrinsic muscles of the thumb) and the ulnar nerve (sensory to the medial part of the hand on both sides, the little finger and the medial half of the ring finger, and motor to all of the other intrinsic muscles of the hand, the flexor carpi ulnaris and the medial half of the flexor digitorum profundus).

This injury to the eighth cervical and first thoracic nerves results in paralysis of the flexor muscles of the digits, the intrinsic muscles of the hand and loss of sensation along the medial aspect of the extremity. Avulsion of the nerve roots near the cord is also associated

(Continued on Page 1046)

Teamwork

Conducting the affairs of the Michigan State Medical Society is not a one-man job. With fifty-five component County Medical Societies, nearly 5,000 members, and an annual budget of over $100,000, this is big business. To do this work well requires good teamwork of the officers, the Council, the House of Delegates and individual members. That we have enjoyed good teamwork this year is evident. The work has been harmonious and fruitful. Many important problems have been settled, others are well along in the process of solution, still others appear to be insoluble at this time. They will be solved in the future. The program of the Michigan State Medical Society is a broad and continuing one. Not all of our objectives will be reached in any one year.

This is the last time the present writer will be privileged to speak to you through the medium of the President's Page. By the time this issue of THE JOURNAL reaches you, there will be a new team in the field; a team made up of seasoned veterans in Society work and promising recruits who will bring enthusiasm and imagination to the group. Thus, we shall be assured of stability and progressiveness in our approach to future problems.

This new team will be captained by our incoming President, Dr. Edward F. Sladek, a man abundantly prepared to assume the responsibilities of the important office of President of the Michigan State Medical Society. He is deeply interested in scientific medicine and thoroughly informed on the many socio-economic problems that face us. Throughout long years of service he has repeatedly demonstrated his willingness and ability to serve the Society well.

May I bespeak for Dr. Sladek the same loyal support you have accorded me, and at the same time thank you sincerely for your most generous co-operation during the past year. In his attitude toward Society work, let each member continue to embrace the philosophy expressed in the old Chinese proverb, "It is better to light one candle than to curse the dark."

P. L. Ledwidge

President, Michigan State Medical Society

President's



Page

Editorial

EXECUTIVE SESSIONS—AMA HOUSE OF DELEGATES

THE AMERICAN Medical Association, governed by a representative House of Delegates, represents democratic principles in action. The House of Delegates used to meet during the period of the Annual Scientific Assembly, the Delegates taking time out to carry on the necessary business. In later years the business of the Association has become so extensive, so voluminous, and so important that it has become necessary for the House of Delegates to meet two days in advance of the scientific program so that they may be finished in time to enjoy a part of that program.

For many years it has become customary for the State Societies to be represented at the AMA House of Delegates not only by regularly elected delegates, but by some of their executive officers, the President, President-Elect, Secretary, and Editor. These officers attend the entire session, where the affairs of our profession are studied and guided. Officers of the State Societies must be familiar with these problems on the national level in order to cope with them at the state level. In fact it has been our experience for the past decade that many of the vital affairs and much of the vital business of medicine has had to be solved on the state level before the national organization became interested.

Lately, our state executive officers have been driven out into the halls when someone had an urge for an "executive session," then after a while could drift back into the House of Delegates meeting, only to be driven out again. This has happened two or three times during an afternoon. Because they have been living with these problems all the year, these executive officers frequently know more about the matter to be taken under discussion than the delegates, but they have been excluded when their advice could have been of great importance.

Reasons given for this action are that many problems require confidential study, and executive sessions are the only feasible method of action. Premature publication seems to be the bugaboo, and in order to exclude the press all but voting delegates and AMA officers are thrown out. This works an unfair hardship upon the state societies that have had the forethought to have their executive officers attend, and upon the busy men who have left their homes several days in advance of the regular program in order to keep themselves well informed and to be able to help also in advising their delegates.

Of what advantage are executive sessions? Within three minutes after the session, and many times even before the matter has been presented to the executive session, the press and everyone else who wishes knows what has occurred and has learned the subject matter in all its details.

We believe the Presidents, Presidents-Elect, Councilors, Secretaries, Editors of our state societies are just as trustworthy as the elected delegates. They are the ones who, in the very nature of things, must carry out the programs and decisions of the national body, and in order to be able to do so they must have the privilege of first-hand knowledge. We suggest an amendment to the AMA By-Laws, that the above-named officers "shall be admitted to all sessions, both general and executive, of the House of Delegates of the American Medical Association."

The rule on executive sessions of the AMA must be revised.

BLUE SHIELD AND SOCIALIZED MEDICINE

ON ANOTHER page† we are publishing the speech given by General Paul R. Hawley, chief executive officer of the Blue Cross and Blue Shield Commissions, at the Annual Conference of Presidents and Other Officers, in Chicago, June 20, 1948. He was also invited to give the same talk to the House of Delegates of the American Medical Association, and did so in executive session, with your President, President-Elect, Chairman of the Council, and Editor excluded. Presumably that group could not be trusted with vital affairs of the medical profession, as being studied by the House of Delegates, even though the Hawley speech had been given in full open session of the wide-awake Conference of Presidents.

The Editor and several others from Michigan who attended the Blue Cross-Blue Shield joint conference in Los Angeles in March had talked with

†See page 954.

Dr. Hawley and knew his views on the immediate future of medicine. We had a copy of this speech and contemplated using extracts from it in THE JOURNAL, but were restrained by the show of secrecy at Chicago. We were respecting the action of the House of Delegates. But publicity has already been given—in the August number of the *Journal of the Iowa State Medical Society.*

We believe there is so much of general interest in this talk that every member of the Society should have a chance to read it, to ponder, and to be ready for action. The General does not think we will be nationalized during the present war scare because there will be other uses for the money. He believes the war threat will have been quieted within the next three years, in which case money will be diverted to other purposes, and the social planners will not miss a trick. If all the resources of the nation are not to be used for defense, they will be clamoring more than ever for their particular ideas, and the urge may be so great that the befuddled people will succumb, as has Great Britain.

The decision lies with the medical profession—to DO and to INFORM in such a wholesome wholesale manner that the public will not be fooled into rash actions.

FEDERAL INCOME TAXES

LAST MONTH we invited attention to the amounts of our earnings that can truly be called income, or *take-home pay.* Taxes rated on the ability to pay seem to be the aim of the graduated surtaxes now being exacted from our people. The graduated surtaxes place a hardship upon the professional men. The legal professions, through the Section on Corporation, Banking and Mercantile Law of the American Bar Association, has offered amendments to the internal revenue code to remedy certain inequalities.

The term "ability to pay" is the concept now regarded as fundamental justice in taxation. It subjects the professional man to so great a burden in taxation during his limited number of peak earning years that he cannot plan for his inevitable lean years and gradual retirement. *The Journal of the Iowa State Medical Society* for August, 1948, says editorially:

"Because the treasury needs revenue at least once every twelve months, it does not follow that the taxpayer's ability to pay should be measured arbitrarily by reference to income received over any particular twelve-month period. The unfortunate lot of the professional or salaried taxpayer is the result of an unfair and discriminatory scheme of taxation, for under the present law, partners and individual proprietors may not be included in pension plans as may business executives.

"The American Bar Association has proposed that these discriminations and injustices be rectified as soon as Congress can be persuaded to do so by the following changes in the law: (1) The adoption of an amendment to the existing pension trust provisions permitting partners and individual proprietors to formulate pension plans, the costs of which are deductible in computing their income taxes. This would remove the discrimination now existing as against sole proprietors or partners. (2) The adoption of a personal and individual retirement plan. Under such a plan every person with earned income (whether partner, self-employed, or employe) would be permitted to set aside some of his own income for his old age. This he would do by purchasing from current earned income a limited amount of special, non-negotiable government bonds, the cost of which would be excluded from the income in the year of purchase for tax purposes. The suggested limit of 15 per cent of earned income, or $10,000, whichever is less. In later life, when he cashes any of the bonds, the proceeds thereof become taxable as income for the year in which cashed."

EUGENE A. OSIUS, M.D.



DR. EUGENE OSIUS has been appointed to represent the sixteenth district in Detroit on the Council of the Michigan State Medical Society, taking the place of Dr. E. R. Witwer, who resigned.

Dr. Osius was born March 4, 1898. He was educated in the Detroit Public Schools and the University of Michigan, receiving his M.D. degree in 1921. He served his internship in Massachusetts General Hospital, and Herman Kiefer Hospital, where he did special work. He served as medical and surgical resident at Harper Hospital from January, 1924 to July, 1927, during which time he acted as assistant superintendent. He spent one year in graduate study in Berlin, Budapest and Vienna. He established his practice in surgery in Detroit in 1928.

He was married in 1930 and has two sons.

Dr. Osius served in the First World War in the Navy, not getting overseas. In the Second World War he was a Commander in the Medical Corps of the Navy, had two years' overseas duty in the

South Pacific, on the Solomon Islands, Tulagi and New Hebrides. He was also stationed at Great Lakes Naval Hospital for about a year just before and shortly after the close of the war. He was connected with the USN Base Hospital No. 7 and No. 3, and MOB Hospital, No. 6. He returned to practice in Detroit in February, 1946.

He is assistant Professor of Clinical Surgery at Wayne University School of Medicine. Attending Surgeon at Harper Hospital, Children's Hospital of Michigan; Associate Surgeon, Receiving Hospital; Consulting Surgeon, Herman Kiefer Hospital; Consulting Surgeon, Veterans Administration Hospital at Dearborn; Diplomate, American Board of General Surgery; Fellow, American College of Surgeons; member, Central Surgical Association; Detroit Academy of Surgery; Detroit Academy of Medicine; Detroit Medical Club; Detroit Medical History Club; and American Medical Association. Besides all this, the doctor plays the cello.

The Council welcomes him to its ranks.

E. R. WITWER, M.D.

DR. E. R. WITWER has served many years on the Council of the Michigan State Medical Society, representing the sixteenth district in Detroit. He has been very active; chairman of the Finance Committee, always a hard worker and a man of sound judgment. He never missed a meeting when it was physically possible for him to attend.

His services to the Michigan State Medical Society were outstanding. He has just recently served a term as president of the American Roentgen Ray Society.

For several months, Dr. Witwer's health has been poor, and he has now resigned from the Council. We all regret this necessity. We shall miss his presence and advice, and we all wish him a speedy return to health.

LIFE EXPECTANCY

"Your date with death has been postponed a good many years by the modern medical and hospital care," says Frank G. Dickinson, Director of the Bureau of Economic Research of the American Medical Association. "A child born in 1847 could expect to live until he reached forty; by 1900 life expectancy had reached forty-nine years; in 1947 the life span is estimated to be sixty-seven, an increase of more than twenty-five years during the last century."

DETROIT INSTITUTE OF CANCER RESEARCH

The first annual scientific meeting of the Detroit Institute of Cancer Research, a symposium on the Fundamental Properties of Protoplasm, will be held at The Rackham Memorial Building, 100 East Farnsworth Street, Detroit, Michigan, October 4, 5 and 6, 1948.

Monday Morning

Recent Work with Crystalline Enzymes
Carl F. Cori, Washington University, St. Louis.
Studies of Human Plasma Lipoproteins
John L. Oncley, Harvard University, Cambridge.
Mucopolysaccharides and Mucolytic Enzymes
Karl Meyer, Columbia University, New York.

Monday Afternoon

Hydration of Viruses and Proteins
Max A. Lauffer, The University of Pittsburgh, Pittsburgh.
Evidence for the Conversion of CO to CO_2 by Living Tissues
Wallace O. Fenn, University of Rochester, Rochester.
Cell Transformations and their Physical Basis
T. M. Sonneborn, Indiana University, Bloomington.

Monday Evening

Dinner and scientific session will be held in co-operation with the Wayne County Medical Society.
The Biological Assessment of Tissue Potentialities
Harry S. N. Greene, Yale University, New Haven.
Auditorium of the Detroit Institute of Arts.

Tuesday Morning

Dietary Aspects of the Tumor Problem
C. A. Baumann, University of Wisconsin, Madison.
Quantitative Aspects of Radiation Carcinogenesis in Humans
Robley D. Evans, Massachusetts Institute of Technology, Cambridge.
The Mechanism of Action of Radiation on Cells and Tissues as Indicated by Genetic Evidence
H. J. Muller, Indiana University, Bloomington.

Tuesday Afternoon

Genes and the Functions of Protoplasm
George W. Beadle, California Institute of Technology, Pasadena.
The Natural History of a Cancer
Peyton Rous, Rockefeller Institute for Medical Research, New York.
The Sciences and Medical Progress
Detlev W. Bronk, Johns Hopkins University, Baltimore.

4:30 P. M.

Dedication of Laboratories and Inspection of the building of the Detroit Institute of Cancer Research.
Dedication of Rollin H. Stevens Memorial Laboratories
Douglas Quick, New York.
Following the dedication of the laboratories, refreshments will be served in the Institute building.

Wednesday Morning

Clinical Session
The General Practitioner and the Cancer Program
Charles Cameron, American Cancer Society, New York.
Benign Tumors of the Breast
Murray Copeland, Georgetown University, Georgetown.
Malignant Tumors of the Breast
Stuart Harrington, University of Minnesota and Mayo Foundation, Rochester.

Wednesday Afternoon

Clinical Session
Carcinoma of the Rectum and Sigmoid
Tom Jones, Cleveland Clinic, Cleveland.
Diagnosis and Treatment of Bone Tumors
Bradley Coley, Memorial Hospital, New York.

Pattern Makers for Rural Health

The first Michigan Rural Health Conference held in 1947 may have been started as the result of a "misunderstanding." This statement may seem incongruous when we examine the fine results which were achieved, but, nevertheless, here's the story:

With the publishing of Selective Service statistics in 1943, the people of the United States were shocked at the high percentage of rural youth rejected by their draft boards as being physically unfit for military service. Without all the facts, rural people throughout the country became perturbed and resentful at what appeared at first reading to be the unhealthy state of farm people as a whole. The proponents of socialized medicine sought to capitalize upon this discontent, and broadly circulated these statistics, with misleading and untrue interpretations.

Statistics Prove

Maurice Friedman, M.D., in his article "Doctor, My Statistics Feel Funny" in the *Nation's Business* magazine asserted:

"Draft figures have been used to prove us a nation of weaklings and cripples. Let's look at the facts . . . to quote from the exact words of the officials of the Selective Service System: 'There seems to be little doubt that most of the registrants being classed as available for limited military service and a substantial portion of the registrants being classed as disqualified for any military service in the United States Army possess health conditions which would be acceptable for military duty in any army in continental Europe.'

"In addition to the non-disqualifying defects, a large proportion of the disqualifying defects were minor in so far as *health* conditions are concerned. The loss of an index and middle finger, the loss of a great toe, or the fact that a registrant is less than sixty inches in height is sufficient cause for rejection, but *such conditions do not indicate that the registrant is in poor health.*"

Facts like these brought new light to bear on the subject of the health of rural people. But there was yet another factor to be revealed by a re-examination of the Selective Service statistics.

An Impartial Study

The Brookings Institute Report, an impartial, scientific study on health made for a United States Senate committee, revealed that the so-called "draft statistics," when compared to population figures as a whole, actually demonstrated the exceedingly high quality of medical care in our country.

To explain this further, the Brookings Report said:

"It seems reasonable to assume that the better the medical care in a country, the larger the number of its people who will be living despite accidents, illnesses, and impairments. Medical care, however adequate, cannot prevent many of these things. It cannot invariably effect a cure or restoration that will bring the individual up to or above the minimum standard for rigorous physical activity such as that used for the armed forces. But it may and does enable the victims of accidents and many diseases to live and support themselves and those dependent upon them."

As the Brookings Report pointed out, a Spartan program of eliminating the physically and mentally unfit would yield a higher percentage suitable for military service than would a program of doing everything possible through medical care to preserve life and to enable persons to make that life worth while, despite conditions that make them ineligible for military service.

In addition, the Brookings Report revealed that the southern negro population, which has materially poorer health than whites, due to economic, educational, and social conditions, was used to reflect on the rural health of the entire United States.

The revelation of these facts indicated that the rural people of Michigan weren't so bad off after all. However, interest in improving health had been engendered by the war and its emphasis on physical fitness. Radio and newspapers were playing up the new medical discoveries. Thus, because of the fears aroused by the "misunderstanding" of false interpretation of Selective Service figures plus the stimulated interest caused by publicity and war, an evaluation of health and health services began to be made in every section of the nation. Also, as a consequence of this new and growing interest in the problem of health, many organizations of varied types began to investigate how they could be of service in improving health generally. It was from this soil that the Michigan Rural Health Conference grew.

The Michigan State Medical Society, determined to be in the first line of attack on this national problem, saw the advantages to be gained for the people if all of the various organizations interested in rural health could meet and discuss their problems; set up ways and means for surveying the needs which existed; and develop suitable projects to meet these needs.

The Fountainhead

Before the Michigan State Medical Society plans could be put into operation, however, a National Rural Health Conference was called in Chicago by the American Medical Association. This proved to be the catalyst. On the concluding day of this Conference, E. F. Sladek, M.D., Traverse City, former Chairman of The Council and now President of the Michigan State Medical Society, J. S. DeTar, M.D., Milan, Speaker of the House of Delegates, and representatives from Michigan State College, Michigan Farm Bureau, Michigan State Grange, and other medical, farm, and lay representatives to the National Conference met together and decided to call for a similar conference in Michigan.

This plan was presented to the MSMS Committee on Rural Medical Service under the Chairmanship of H. B. Zemmer, M.D., Lapeer, who in turn referred it to The Council of the MSMS with a recommendation for its immediate implementation. The Council acted upon the recommendation at once. They approved it and simultaneously made finances available to pay for the complete cost of a Michigan Rural Health Conference.

The Wheels Turn

With the preliminary steps taken, the machinery for organizing and carrying the Conference through was set in motion. Invitations were sent to organizations which had indicated their interest in a meeting of this nature, and twenty-nine of these organizations volunteered their services as co-sponsors.

Michigan State College, through its Extension Service, invited the Michigan State Medical Society and the other co-sponsors to hold the meeting on the campus of the College, and the date was set for September 18-19, 1947.

The next step was to set up a comprehensive program and obtain speakers who were authorities in their fields. A Committee on Arrangements was selected under the leadership of H. B. Zember, M.D., and a tentative schedule and program for the first Conference was drawn up. Members of the Committee submitted suggestions for speakers and discussion leaders, and invitations to attend were sent to organization representatives and through publicity to the general public.

The First One

The method of procedure for the 1947 Conference was as follows: On the opening afternoon, September 18, following the four principal talks delivered by Emory W. Morris, D.D.S., Battle Creek, A. C. Furstenberg, M.D., Ann Arbor, L. Fernald Foster, M.D., Bay City, and Miss Marion I. Murphy, R.N., Ann Arbor, the Conference divided into section meetings.

These meetings were conducted by discussion leaders, and each of the speakers was invited to attend as a guest conferee on the topic which he had presented previously.

By utilizing these individual discussion groups, those attending the Conference were able to obtain specialized information and engage in constructive discussion which could not otherwise have been included due to time limitations.

The evening meeting was devoted entirely to a talk on "The Relation of Good Soil, Good Agriculture, and a Sound Economy to the Health and Well-Being of Rural Communities" by Mr. Louis Bromfield, famous author, farmer and lecturer.

On the following morning, September 19, talks were delivered by R. H. Pino, M.D., Detroit, Charles P. Loomis, Ph.D., East Lansing, and J. S. DeTar, M.D., Milan. Reports of the preceding day's section meetings were presented, and a summary of the Conference was given by Hardy A. Kemp, M.D., Detroit.

Out of each of the discussion groups came resolutions designed to implement the ideas and suggestions presented at the Conference.

Resolutions and Results

These resolutions, as formulated by the various discussion groups, were not allowed to "die on the vine" as is so often the case. The resolutions and the action taken to implement them over the course of the following year were as follows:

RESOLUTION: That this conference set up a committee to plan and to organize a medical scholarship fund, either by contribution or leg-

islation, for students who will practice in rural areas.

ACTION TAKEN: The Michigan Foundation for Medical and Health Education, Inc., appreciating the need for more doctors of medicine in rural areas, has established a revolving loan fund known as the "Fund for the Encouragement of Medical Practice in Rural Areas." The administration of this program is under the direction of a qualifications committee. The funds are distributed in the form of loans to those students presently in the upper classes of the medical schools, or to interns or residents in hospital service who require financial aid.

RESOLUTION: That this conference go on record as favoring an increased appropriation for use by our medical schools for medical education.

ACTION TAKEN: There has as yet been little opportunity for adequate legislation of this nature to be introduced in Michigan. However, the passing of Act 346 of the Public Acts of 1948 by the Special Session of the Michigan Legislature, providing $1,645,000 for the construction of a Maternity Hospital at the University of Michigan will greatly increase the facilities for training doctors at the University of Michigan Medical School.

RESOLUTION: That this Conference set up a committee to plan and assist in the organization of local health councils in rural areas under the leadership of the Michigan Health Council for the purpose of assisting, co-ordinating, and implementing all programs contributing to the health of the people.

ACTION TAKEN: The Michigan Health Council is being reorganized to bring in more interested organizations and individuals. It is proposing to invite into its membership such lay organizations as the Michigan Congress of Parents and Teachers, Michigan State Grange, Michigan Society for Crippled Children and Adults, and similar groups. Further, consideration is being given to a proposal that associate memberships be given representatives of community health councils, which membership properly organized would constitute an advisory board.

Community health councils will work on the community level to further any health project of a desirable nature being considered in their particular communities. The community health council will obtain all desired assistance from the Michigan Health Council.

The Michigan State College Extension Service has taken an active interest in community work affecting health; a committee has been appointed to consider this type of activity. The College is also considering hiring a specialist in rural health to assist in this work.

RESOLUTION: That this group go on record as favoring a hospital licensing law for Michigan.

ACTION TAKEN: Legislation was passed in the 1948 special legislative session which provides that hospitals receiving federal aid under the Hill-Burton (Federal Hospital Survey and Construction Act) must comply with certain standards of maintenance and operation.

RESOLUTION: That all possible encouragement be given 4-H and other local community activity groups for recruitment of nursing students; and that these groups work for the establishment of scholarships for the assistance of young women entering a school of nursing.

ACTION TAKEN. An intensive nurse recruitment campaign has been carried on by the Michigan Nursing Center Association. Their representatives have visited high schools, contacted churches, and worked closely with the 4-H Club in an effort to spur enrollment in schools of nursing.

On Wednesday, May 12, National Hospital Day, the nurses held open house at hospitals throughout Michigan for young women who felt that they might be interested in taking up nursing as a career.

To further encourage enrollment in schools of nursing, the Bureau of Public Health Nursing has asked the co-operation of physicians, health officers, and nurses in locating the most promising students and nurses for public health training during the coming year. The University of Michigan School of Public Health also offered six $100 scholarships to cover the expenses and tuition of a course in cancer nursing at the University of Michigan, June 21 to July 3, 1948.

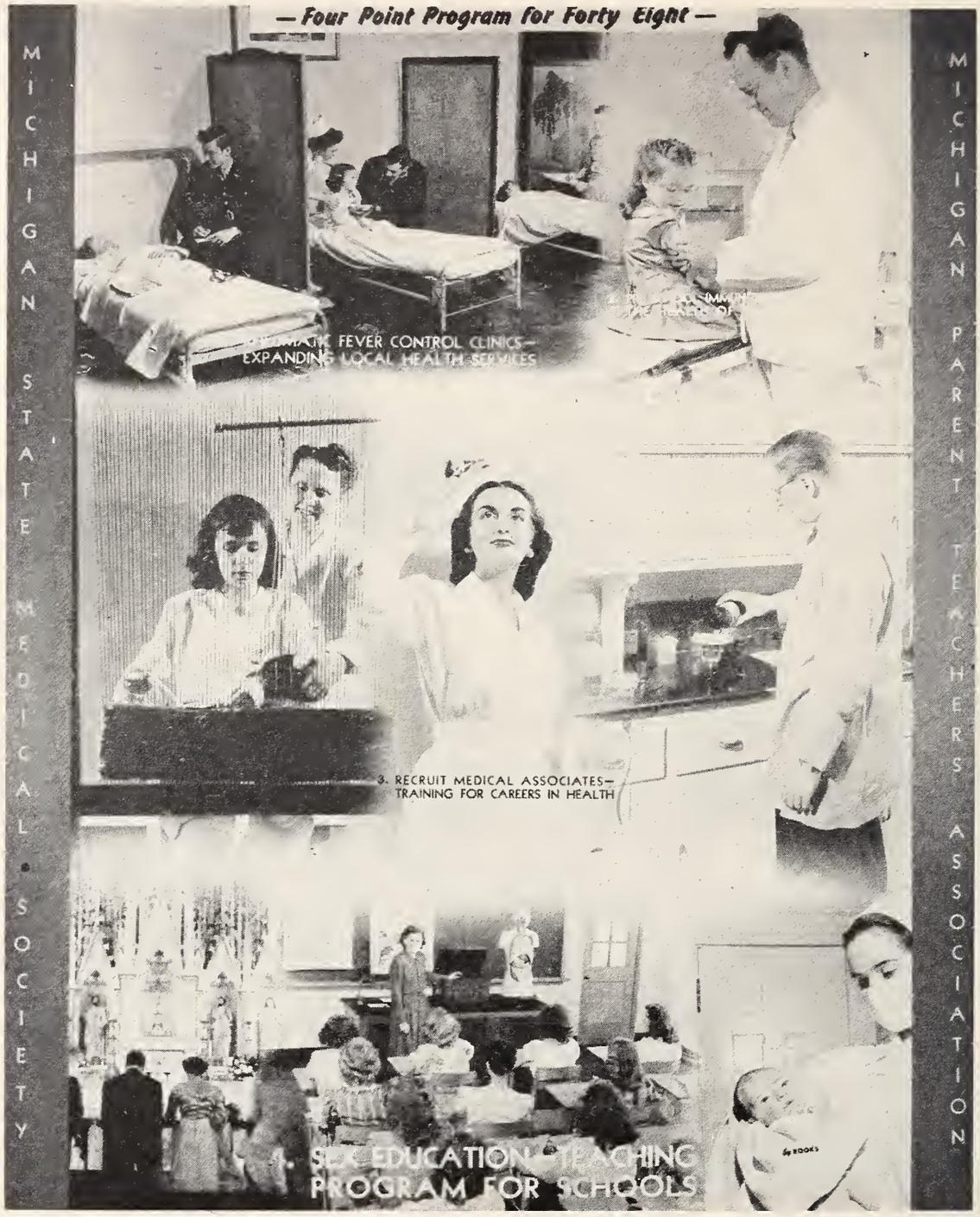
In addition to these projects, the *Medical Associates* brochure, published by the Michigan State Medical Society, is now being distributed throughout the state. This illustrated booklet contains a section outlining the opportunities which are open

to young women in the vocation of nursing as well as in other fields of medical associates.

The Woman's Auxiliary of the Michigan State Medical Society has set up nursing scholarships in several counties and has made nurse recruitment a major project for 1949.

RESOLUTION: That this conference set up a committee to arrange for a second Rural Health Conference in 1948, and assume responsibility for implementing the resolutions passed by this conference.

ACTION TAKEN: The Executive Committee of The Council of the Michigan State Medical Society agreed on March 9, 1948, to sponsor the Second Annual Michigan Rural Health Conference. The Committee on Arrangements of the Michigan Rural Health Conference has carried through.



News to the Nation

In the meantime, upon the conclusion of the 1947 Conference, work was started upon a brochure designed to give a complete résumé of the

proceedings of the meeting in a condensed form. It was felt by Chairman Zemmer that this booklet would answer the many inquiries which were flooding in from all parts of the country.

A first printing of 2,000 copies was made, but the distribution of 1,000 copies of the brochure at the American Medical Association Annual Session in Chicago in connection with the MSMS Rural Child Health Exhibit resulted in still more requests for the booklet. Hundreds of these inquiries for further information about the Michigan Rural Health Conference come in from states as far distant as Mississippi, Oregon, California, Connecticut, Texas, Oklahoma, and from the District of Columbia.

The demand outdistanced the supply, and it was necessary to order a reprint of 1,500 in order to fill every request. This was but one of the symptoms of the tremendous interest aroused by the first Michigan Rural Health Conference.

40 in '48

Prior to the 1947 Conference, the Michigan State Medical Society had made no commitments on continuing its sponsorship on an annual basis. However, with the enthusiastic response accorded by rural and health people alike, it was decided by the Committee on Rural Health, with the approval of The Council of the MSMS, to sponsor the Conference in 1948.

In the spring of this year invitations were sent out to co-sponsors of the Conference for 1947 and to new co-sponsors who had indicated their interest. Forty organizations accepted the invitations, and a meeting of representatives of the co-sponsors was arranged in the Hotel Olds, Lansing, Michigan, on July 14.

Pattern Makers

At this meeting a tentative program was presented by the Committee on Arrangements for approval, and suggestions were invited for improving it. Among the numerous constructive criticisms received was one from Stanley Powell, Michigan Farm Bureau representative. He stated it was felt by many that the Conference would be more valuable if farm people could participate more actively in the Conference program. Dr. Zemmer replied by pointing out that this year's program had been set up in an attempt to do that very thing. He explained that this was to be accomplished by farm representatives occupying positions of leadership on the program, and by inviting participation in group discussions, as well as by encouraging questions from the floor.

The representatives were also invited to submit their suggestions for speakers on the program. This was done, and at a subsequent meeting of the Committee on Arrangements held on July 28, a final determination of speakers, discussion leaders and program structure was made.

Second Michigan Rural Health Conference, September 16-17, 1948

On Thursday, September 16, the program was opened at 1:30 p.m. by the resounding gavel of H. B. Zemmer, M.D., Chairman of the Conference. Hugh W. Brenneman, Secretary of the Conference, then read a communication from Governor Kim Sigler, Honorary Chairman, which stated in part:

> "The basic structure of Michigan prosperity rests on rural people. Nothing could be more important than the health of this vital segment of our population. I wish this Conference success in searching the avenues of health so that Michigan may continue leading the way in health progress."

Following a review by Dr. Zemmer of the progress which had been made on the resolutions adopted at the previous year's Conference, the guests were officially welcomed to the campus of Michigan State College by C. V. Ballard of the Extension Service, M.S.C.

Headliner on the evening session was Senator Homer Ferguson, Detroit.

Speakers at the four main sections and their subjects were as follows:

- Professor Howard McCluskey, Ann Arbor—"Planning for Healthy Communities"
- Albert E. Heustis, M.D., Lansing, "Modern Medicine in Rural Michigan"
- Gen. Paul R. Hawley, Chicago—"Dollars and Disease"
- Ruth Parsons, Fowlerville—"Youth in the March of Health"

These talks were preceded by a report by C. R. Hoffer of M.S.C. of the progress being made on the Michigan Rural Health Survey, sponsored by M.S.M.S. and the Michigan Foundation for Medical and Health Education.

The subjects of the four talks were then used as the topics for the four main sections. These with their subsections were:

"Planning for Healthy Communities"—community health councils, health programs of organizations, local health department activity, and disease control programs.

"Medical Care in Rural Michigan"—bringing and holding doctors in rural areas, education in health for rural people, mental health in Michigan, and nursing and Medical Associates.

"Dollars and Disease"—voluntary prepaid group medical and hospital service, the hospital survey and construction act, aid to the medically indigent, and contributions of voluntary health organizations.

"Youth in the March of Health"—dental care, child guidance clinics, prevention of children's diseases, and school health programs.

In addition to these topics which were much wider in scope than those of the previous year, due to the subdivisions included, a panel discussion on each of the topics discussed was presented on the final day of the Conference. The inclusion of this feature allowed maximum audience participation.

The Conference, which had a record attendance of over 547, a gain of 100 over the previous year, has been acclaimed an outstanding success by rural and medical people throughout Michigan and the United States.

—— And Thank You, Dr. Zemmer

To quote Conference Chairman H. B. Zemmer, M.D.:

"I sincerely feel that this second annual Michigan Rural Health Conference has made a significant contribution to the solution of some of the problems of rural health. To all of these people who have so unselfishly devoted their time and skill to this meeting may I offer my most heartfelt thanks."

For copies of the second annual Michigan Rural Health Conference Brochure, which is now in the process of preparation, write the Michigan Rural Health Conference, 2020 Olds Tower, Lansing 8, Michigan.

MICHIGAN MEDICAL SERVICE

Annual Meeting of the Corporation

The annual meeting of the MMS Corporation, which is composed of the House of Delegates of Michigan State Medical Society, plus the hospital representatives and lay members of the Board, was held September 20, 1948, in conjunction with the annual meeting of the Michigan State Medical Society. The following were elected to the Board for a three-year term: R. L. Novy, M.D., Leon Bogart, M.D., R. H. Baker, M.D., W. B. Harin, M.D., S. W. Insley, M.D., Frank E. McAllister, Chairman of the Board of Home Savings Bank, Kalamazoo, John Reid; two members of the Hospital Association—William Rottschaeffer, M.D., University of Michigan Hospital and M. F. Capra, McPherson Memorial Hospital, Howell, Michigan. Also elected for an unexpired one-year term was Harry Becker, UAW-CIO Social Security Board. The next meeting of the Board of Directors will be held early in October.

Many important subjects were discussed, among which were the following:

(1) A new surgical contract providing surgical services for subscribers where the three-year average family income is not in excess of $4,000 or where the single subscriber three-year average income is not more than $3,000 will be issued as soon as feasible. In conjunction with this contract, a new fee schedule will be promulgated. Fees will be increased 50 per cent on all surgical procedures and adjusted to round figures. It will also provide for an increase in membership fees.

Each subscriber will be entitled to $25.00 x-ray services in any one certificate year in accordance with the Schedule of Benefits.

Rates on the new contract will be: single subscriber 90c to $1.35, depending upon the number of females in the group; two-person contract (husband and spouse) $2.20; and full family $3.25.

This is a completely new certificate which will be issued after many years of deliberation and consideration and in recognition of the current economic situation.

New medical-surgical and direct payment contracts will be issued simultaneously.

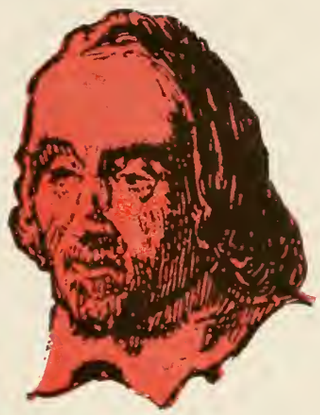
It was announced that this contract does not supersede the present surgical or medical-surgical contract which provides surgical services for subscribers where the three-year average family income is not in excess of $2,500 or where the single subscriber three-year average income is not more than $2,000.

Each employer group, as a group, will decide which type of contract they desire. In other words, it will not be possible in one employer group to have both types of contracts. This ruling is necessary in order to minimize problems of administration.

(2) There was considerable discussion regarding a proposed Blue Cross-Blue Shield Association and Blue Cross-Blue Shield Health Service, Inc. The subject of expanding the present Blue Cross Commission and expanding Associated Medical Care Plans Commissions (Blue Shield) has been under consideration for some time. The problem of furnishing a uniform contract to national employers has also been under consideration for many years. Blue Cross-Blue Shield Association and Blue Cross-Blue Shield Health Service, Inc., pamphlets were furnished all the members of the corporation. After considerable discussion, on motion made these matters were tabled, leaving it in the hands of the Board of Directors.

(3) It was announced that Michigan Medical Service was the first voluntary prepaid medical-surgical plan to enroll in excess of one million members.

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Wayne University College of Medicine

September 20 - December 11, 1948

These courses are open to all qualified persons.

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If you do not possess a Certificate of Eligibility, please call Mr. Johnson at Temple 1-1450, Veterans Affairs, before going down to his office, and he will inform you what papers it is necessary to bring with you. *This must be completed before you register.*

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine *before September 17.*

Title of Course	*Place*	*Time*	*Fee*
ANATOMY			
Human Inheritance	College of Medicine	Arranged	$25.00
Readings in Physical Anthropology	College of Medicine	Arranged	$25.00
PATHOLOGY			
Beginning Hematology	College of Medicine	Friday 1-5	$50.00
Surgical Pathology	College of Medicine	Wednesday 1-5	$50.00
Pathology of Parasitic Diseases	College of Medicine	Monday 1-5	$50.00
PHYSIOLOGICAL CHEMISTRY			
Seminar	College of Medicine	Wednesday 4-5	$15.00
PHYSIOLOGY AND PHARMACOLOGY			
Survey of Physiology	College of Medicine	Tuesday 4-5	$15.00
DERMATOLOGY			
Seminar	Receiving Hospital	Wednesday 10-12	$15.00
Conference on Venereal Diseases	Social Hygiene Clinic	Thursday 4-5:30	$15.00
INTERNAL MEDICINE			
Diagnostic Conference	Receiving Hospital (Limit 10)	Saturday 10-12	$15.00
	Wayne County General	Wednesday 4-5	$15.00
Gastroenterology	Receiving Hospital (Limit 10)	Saturday 8-9	$15.00
Medical X-Ray Conference	Receiving Hospital (Limit 10)	Tuesday 11-12	$15.00
	Wayne County General	Friday 1-2	$15.00
Medical Pathologic Conf.	Wayne County General	Thursday 11-12	$15.00
Allergy Clinic & Conf.	Receiving Hospital	Tuesday 8-11	$25.00
SURGERY			
Seminar	College of Medicine (Limit 20)	Thursday 4-5	$15.00
Comprehensive Unit Courses			
OPHTHALMOLOGY			
Basic Ophthalmology	College of Medicine (Limit 10)	Full Time (9 months)	$900.00
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General Pathology	College of Medicine (Limit 5)	Full Time (9 months)	$500.00

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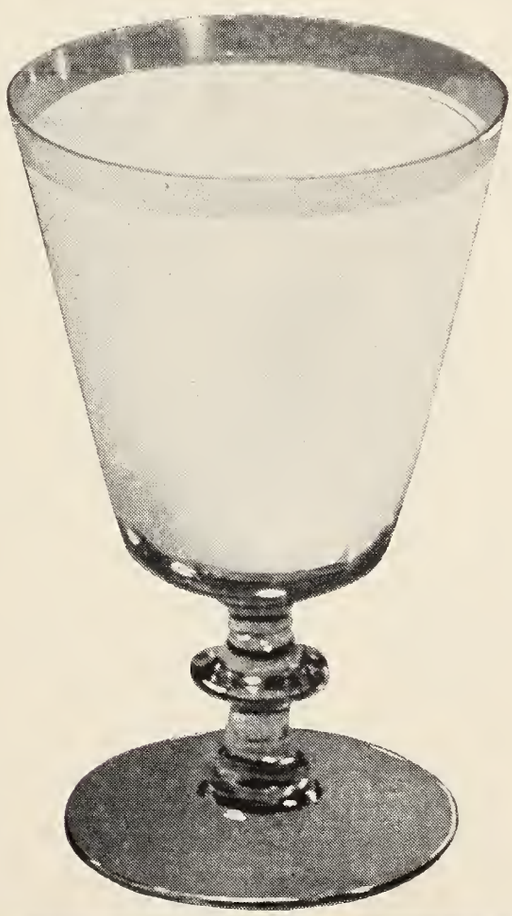
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MICHIGAN STATE MEDICAL SOCIETY

Supplemental Roster 1948

(The following names were certified by County Medical Societies after the Roster had been sent to publishers of THE JOURNAL. Included are corrections to the original Roster as it appeared in the July number.)

Alpena County

Bergin, Joseph L.....Alpena
O'Boyle, C. P.....Alpena
Purdy, J. W.....Alpena

Berrien County

Conway, Joseph.....Watervliet
Fattic, G. R., Jr.....Niles

Calhoun County

Altman, George L. .....
(M) Battle Creek (Cor.)
Lowe, Kenneth H.....Battle Creek (Cor.)
Schwarz, Frank W.....Battle Creek (Cor.)
Walker, Charles S.....Battle Creek

Dickinson-Iron Counties

Frederickson, Geron.....Iron Mountain
Menzie, Clifford.....Iron Mountain

Genesee County

Hing, William.....Flint
Sparks, Harvey V.....Flint (Cor.)

Gogebic County

Anderson, Charles E..... Bessemer (Cor.)
Davidson, Donald L..... Bessemer (Cor.)

Grand Traverse-Leelanau-Benzie Counties

Baker, Dorothy M.....Traverse City
Hyslop, Wm. T.....Traverse City (Cor.)
Merritt, Harry.....Traverse City
Thacker, Fred R.....Frankfort
Van Leuven, B. H.....Traverse City

Gratiot-Isabella-Clare Counties

Elliott, L. E.....Edmore
Johnson, P. R.....Mt. Pleasant

Hillsdale County

Bacon, Glenn A.....(M) Reading
Davis, L. A.....Camden

Ingham County

Behen, Wm. C.....Lansing
Black, Charles E.....Lansing
Black, Gertrude.....Williamston
Calomeni, Anthony D.....Lansing
Clark, Wm. E.....Mason
Clinton, George.....Mason
Cummings, G. D.....Lansing
Dunn, F. M.....Lansing
Fosget, Wilbur W.....Lansing
Hackman, Pearl.....Lansing
Harris, Herbert W.....Lansing
Harrold, J. F.....Lansing
Heald, Gordon H.....East Lansing
Henry, L. L.....Lansing
Hodges, Kenneth P.....Lansing
Holland, Charles F.....East Lansing
LeDuc, Don. M.....Lansing
Martin, Wayne O.....Lansing
McCrumb, R. R.....Lansing
McGillicuddy, Oliver.....Lansing
McGillicuddy, R. J.....Lansing
Morrow, R. J.....Lansing
Myers, Victor C.....Lansing
Potter, Earl C.....Lansing
Randall, O. M.....Lansing
Richardson, M. L.....Lansing
Robson, Edmund J.....Lansing
Rozan, J. S.....Lansing
Sharp, Mahlon.....Lansing
Sherman, G. A.....Lansing
Silverman, Irving E.....Lansing
Strauss, P. C.....Lansing
Stringer, C. J.....Lansing
Towne, Lawrence.....Lansing
Venier, Joseph.....Lansing
Webb, Roy O.....Okemos

Jackson County

Bindshedler, Buell S.....Jackson (Cor.)

Kent County

Bond, George L.....Rapid City
Freyling, Robert A.....
(M) Brooklyn, N. Y.(Cor.)
Hardy, Faith F.....Grand Rapids
Lindenfeld, Fred H. (M).....Niles (Cor.)
MacDonell, James A.....Dearborn (Cor.)
Pott, Abraham L.....Grand Rapids
Stuart, G. J.....Grand Rapids
VanderMeer, Ray.....Grand Rapids
Winter, G. E.....Grand Rapids
Wurz, John F.....Grand Rapids

Lapeer County

Dorland, Clarke.....Lapeer (Cor.)

Luce County

Perry, Henry E.....Newberry (Cor.)

Macomb County

Parker, B. Morgan.....Utica (Cor.)
Revere, J. O.....Mt. Clemens

Marquette-Alger Counties

Knutson, George O.....Negaunee (Cor.)

Northern Michigan

Trudeau, J. M.....Alpena

Oakland County

Cottrell, Martha.....Novi

Ottawa County

Van Appledorn, C. J.....Holland (Cor.)

Saginaw County

Bagshaw, David E.....Saginaw
Bishop, H. M.....Saginaw (Cor.)
Eymer, Esther.....Safello, N. M. (Cor.)
Gage, David P.....Saginaw
Harvie, L. E.....Saginaw
Hill, Victor L.....Saginaw
James, J. W.....Saginaw
Ling, Ernest M.....Spring Lake (Cor.)
Lurie, Robert.....Saginaw
Markey, Francis L.....Saginaw
Markey, Joseph P.....Saginaw
Moon, A. R.....Saginaw
Mudd, Richard D.....Saginaw
Murray, Charles R.....Saginaw
Potvin, Clifford D.....Saginaw
Tiedke, G. E.....Saginaw

St. Clair County

Bottomley, Thomas H.....Port Huron
Carey, Lewis M.....Port Huron (Cor.)
Carney, F. V.....St. Clair
Gilmore, John R.....Port Huron
Kimball, F. Bruce.....Port Huron
Holcomb, R. J.....Marine City
Hoyt, Charles N.....Port Huron (Cor.)
Pollack, Donald A.....Yale (Cor.)

Sanilac County

Bennett, Wm. G.....Brown City

Shiawassee County

Dillon, Thomas James.....Perry (Cor.)

Van Buren County

Copeland, Evan L.....Decatur

Washtenaw County

Aldridge, Charles W.....Ann Arbor
Butler, William J.....Ann Arbor
Cheney, William D.....Ann Arbor
Edward, Aaron R.....Ann Arbor (Cor.)
Fuller, William J.....Ann Arbor
Lamberti, Thomas G.....Ypsilanti
List, Martin L.....Ann Arbor
Law, John L.....Ann Arbor (Cor).
Levin, Manuel.....(M) Ann Arbor (Cor.)
Payne, Beverly C.....
(M) Champaign, Ill. (Cor.)
Reiff, William H.....
(M) Stillwater, Okla. (Cor.)
Rowe, Peter.....Ann Arbor
Zinn, Karl.....Ypsilanti

Wayne County

Arnold, Wm. J. Jr.....Detroit
Adair, Robin.....Detroit
Barak, Lewis R.....Detroit
Barnes, Van D.....Detroit
Barnett, Louis L.....Detroit
Belanger, Ernest E.....Detroit
Belknap, Warren F.....Detroit
Beresh, Louis.....Detroit
Bergman, Theodore I.....Detroit
Bittrich, Norbert M.....Detroit
Bloomer, Earl.....Dearborn
Boland, John R.....Detroit
Boyle, Albert J.....Detroit
Brand, Benjamin.....Detroit
Brewer, Wm. A.....Detroit
Broudo, Philip H.....Detroit
Burns, Robert T.....Detroit
Cashen, Russell M.....Detroit
Caven, Hugh J.....Detroit
Collings, M. Raymond.....Detroit
Crawford, Albert S.....Detroit
Davison, Leo E.....Detroit
Doering, Wendell.....Detroit
Erman, Joseph M.....Detroit
Farbman, Simon S.....Detroit
Feldman, N. L.....Detroit
Fulgenzi, Andrew A.....Detroit
Galvin, Paul P.....Detroit
Gingold, Samuel M.....Detroit
Gleason, John E.....Detroit
Gobeille, Alfred B.....Detroit
Goss, Samuel B.....Detroit
Grant, Heman E.....Detroit
Gudes, David S. (M).....Detroit
Hamburger, Albert C.....Detroit
Hamil, Brenton M.....Detroit
Harmon, Walter.....Detroit
Hedgeman, E. Chester.....Detroit
Hendry, H. W.....Detroit
Hill, W. T.....Detroit
Holloway, H. R.....Detroit
Horkins, H. A.....Detroit
Hyland, John.....Detroit
Israel, Barney B.....Detroit
Hughes, Albertie A.....(L) Detroit (Cor.)
Jaeger, Grove.....Detroit
Kasabach, V. Y.....Detroit (Cor.)
Kass, Arnold.....Detroit
Kawecki, Lucian.....Dearborn
Kelly, Edward W.....Detroit
Kleinman, S.....Detroit
Kolasa, Wm. B.....Detroit
Levine, Sydney.....Detroit
Lichter, Max L.....Melvindale (Cor.)
Litsky, Abraham.....Detroit
Markey, Alexander P.....Detroit
Marsden, Thomas B.....Detroit
Mathes, Charles J.....Detroit
Maxwell, J. Harvey.....Detroit
McAlonan, Wm. T.....Detroit
McDougall, Bernard Wm.....Detroit
McIntosh, W. V.....Detroit
McRae, Donald H.....Detroit
Melnik, Maxim P.....Detroit
Merriman, K. S.....Detroit
Miller, Glenn F.....Detroit
Moore, James A.....Detroit
Moss, Nathan H.....Detroit
Molnar, Stephen.....Eloise

Nawotka, Edward E.....Detroit
Newell, Philip D.....Detroit
Noer, Rudolf J.....Grosse Pte. Farms
Parker, Benjamin R.....Detroit
Pensler, M. M.....Detroit
Portnoy, Harry.....Detroit
Polentz, Charles.....Detroit
Procailo, Alex B.....Detroit
Reberdy, George J.....Detroit
Reske, Alven A.....Dearborn
Rosenman, J. D.....Detroit
Rosenzweig, Saul.....Detroit
Ryan, Charles F.....Detroit
Ryan, William D.....Detroit
Saunders, Wm. H.....Detroit
Schane, David.....Detroit
Schneider, Alex N.....Detroit
Scoville, Victor.....Detroit
Selman, J. H.....Detroit
Siwka, Isidore J.....Detroit
Stein, Edward.....Detroit
Stern, Edward A.....Detroit
Stiefel, Daniel M.....Detroit
Stump, George D.....Detroit
Sugarman, Marcus.....Detroit
Szilagyi, D. E.....Detroit
Taylor, Aaron.....Detroit
Taylor, J. L.....Detroit
Torres, Estelle.....Detroit
Tuttle, Wm. M.....Detroit
Vogel, Hyman A.....Detroit (Cor.)
Watson, Harwood G.....Dearborn (Cor.)
Wickham, A. B.....(L) Phoenix, Ariz. (Cor.)
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Wilson, John D.....Detroit
Wood, George P.....Detroit
Zabinski, Edward J.....Detroit
Zukowski, Henry J.....Boston, Mass.

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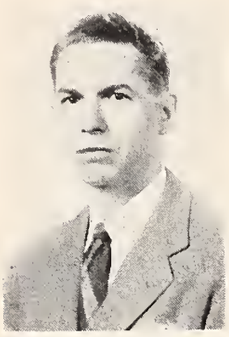
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Michigan's Department of Health

New Commissioner of Health



Albert E. Heustis, M.D., was appointed State Commissioner of Health by Governor Kim Sigler on August 3, 1948. Dr. Heustis had been director of the Branch County (Michigan) Health Department and the Community Health Center of Branch County since 1945.

Dr. Heustis was born in Fitchburg, Massachusetts, April 22, 1913, and has lived in Michigan since 1927. He was graduated from the University of Michigan Medical School in 1936; from 1937 to 1940, he worked under Frederick A. Coller, M.D., Professor of Surgery, serving as intern, assistant resident, resident and teaching assistant in the Department of Surgery. In 1942, he received a Master of Public Health degree from Johns Hopkins University.

Before going to Coldwater in 1945, Dr. Heustis was assistant director and later director of the Monroe (Michigan) County Health Department, and served a year as president of the Monroe County Medical Society.

Dr. Heustis is a trustee of the Michigan Hospital Association and a member of its legislative committee, and is vice president and a member of the Board of Directors of the Southwestern Michigan Hospital Council. He is a trustee and member of the state hospital relations committee of Michigan Hospital Service, and is a non-resident lecturer in public health administration for the University of Michigan School of Public Health. He is now chairman of the Branch County Cancer Committee, and past chairman of both the Monroe and Branch Counties chapters of the National Foundation for Infantile Paralysis and currently is chairman of the Branch County chapter's medical advisory committee. He also serves as secretary of the Interstate Academy of Medicine.

Dr. Heustis is a member of the Michigan State Medical Society, the American Medical Association, the Michigan and American Public Health Associations, the Michigan and American Hospital Associations, and the American School Health Association.

Dr. Heustis is a member of the Coldwater Rotary Club and the board of directors of the Coldwater Chamber of Commerce. He is married and the father of five children.

A total of 144 million patient days' care was provided by 6,173 hospitals in the United States last year. This was an average of eight days for 18 million people. The average stay in hospitals has decreased from 9.1 to 8, and according to the *Indianapolis Commercial,* "This reflects the practice of entering hospitals in earlier stages of illness, possible for increasing numbers of people through Blue Cross and other prepayment plans, as well as a wider recognition of the value of hospitals, improved treatment methods, and early ambulation."



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In Memoriam

FRANK BENJAMIN ALLISON, M.D., Detroit Michigan, was born in 1879. He graduated from the Wayne University College of Medicine, Detroit, in 1905. Doctor Allison had been affiliated with St. Luke's Hospital for twenty-one years. He was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. He passed on in Detroit, Michigan, on June 30, 1948, at the age of sixty-eight years.

EMIL AMBERG, M.D., Detroit, Michigan, was born in 1868 in Santa Fe, New Mexico. He received his medical education at Heidelberg University, where he graduated in 1894, and took postgraduate work in Berlin and Vienna. He was a member of the Wayne County Medical Society, American Medical Association and the Michigan State Medical Society. He was elected Emeritus Member of the State Society in 1944. Dr. Amberg was the inventor of the head mirror now used by surgeons. He served on the staff of several Detroit hospitals. Dr. Amberg died April 12, 1948, in Detroit, Michigan, at the age of seventy-nine.

GEORGE W. BROOKS, M.D., Tustin, Michigan, was born March 8, 1879. He graduated from the Wayne University College of Medicine in 1901. Dr. Brooks was a former member of the Wexford County Medical Society, the American Medical Association, and the Michigan State Medical Society. He had practiced medicine in Tustin for thirty-five years, and passed on after a long illness on July 22, 1948, in Tustin, Michigan, at the age of seventy years.

CLARENCE A. CARPENTER, M.D., Onaway, Michigan, was born in 1875, in Ottawa County, Michigan. He graduated from the Physio-Medical College of Indiana in 1898. He was a member of the Alpena County Medical Society, the American Medical Association, and a Life Member of the Michigan State Medical Society. Dr. Carpenter had practiced medicine in Onaway for forty-eight years. He died in Petoskey, Michigan, on July 17, 1948, at the age of seventy-four.

JOHN A. FREESE, M.D., Detroit, Michigan, was born in 1876. He was graduated from Harvard Medical School in 1907. He was a member of the Wayne County Medical Society, American Medical Association, and was elected a Life Member of the Michigan State Medical Society in 1947. Dr. Freese died October 29, 1947, in Detroit, Michigan, at the age of seventy-three.

BERT C. HALL, M.D., Pompeii, Michigan, was born February 23, 1868, in Owosso, Michigan. He graduated from the Wayne University College of Medicine, Detroit, in 1897. Doctor Hall was made a Fellow of the American College of Surgeons in 1928; he was a member of the Gratiot-Isabella-Clare County Medical Society, the

American Medical Association, and an Emeritus Member of the Michigan State Medical Society. He had practiced medicine in Gratiot County for over fifty years and had operated a private hospital for twenty-five years. Since 1943 he had served as Chief-of-Staff at the Alma Hospital. He died on June 30, 1948, in Pompeii, Michigan, at the age of eighty years.

MARCINE DENVER KLOTE, M.D., Detroit, Michigan, was born in 1902, in Edina, Missouri. He was a graduate of St. Louis University Medical School in 1928 and took graduate work at the University of Michigan. He was a member of the Wayne County Medical Society, American Medical Association, Michigan State Medical Society, Alpha Omega Alpha and Phi Beta Pi. Dr. Klote served on the staff of Providence Hospital. He died on March 24, 1948, in Detroit, Michigan, at the age of forty-five years.

DONALD MACINTYRE, M.D., Big Rapids, Michigan, was born in Ingham County, Michigan, in 1872. He graduated from the Michigan College of Medicine and Surgery, Detroit, in 1897. In 1926-27-28, Doctor MacIntyre was secretary of the Mecosta County Medical Society, and during 1931 served as president of the same Society. He was an Emeritus Member of the Michigan State Medical Society and a member of the American Medical Association. His practice had been limited to Ophthalmology, Otology, Laryngology and Rhinology. Doctor MacIntyre passed on after a long illness, in Big Rapids, Michigan, on June 30, 1948, at the age of seventy-six.

NEIL JAMES McCOLL, M.D., Port Huron, Michigan, was born August 27, 1876, in Clachan, Ontario, Canada. He graduated from the University of Indiana Medical School in 1898. Dr. McColl was a former mayor of Whittemore and of Crosswell, Michigan. He was a former member of the St. Clair County Medical Society, the American Medical Association, and the Michigan State Medical Society. He was well known as a world traveler, having completed two trips around the world. Dr. McColl died on July 25, 1948, after an illness of several months, in Port Huron, Michigan, at the age of seventy-one years.

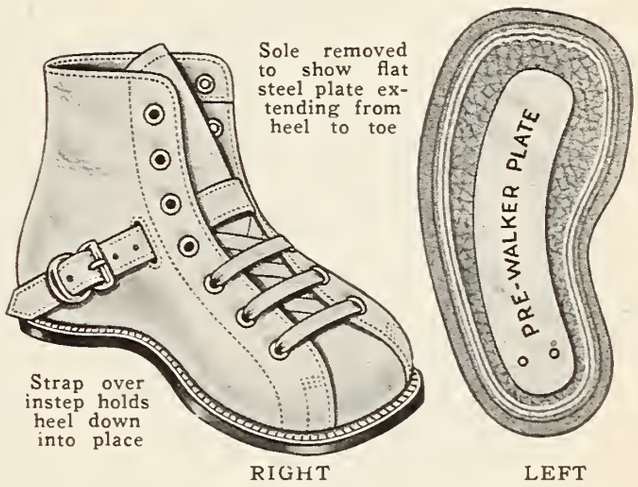
HAWLEY SEAGER SANFORD, M.D., Detroit, Michigan, was born in 1909. He was a graduate of Northwestern University, and Harvard Medical School in 1933. Served with the Medical Corps in World War II. He was a member of the Wayne County Medical Society, American Medical Association, and the Michigan State Medical Society. He was a former member of the Mayo Clinic and since 1937 had served on the staff of the Henry Ford Hospital. Dr. Sanford died March 24, 1948, in Detroit, Michigan, at the age of thirty-nine years.

DAVID ELLICOTT SQUIERS, M.D., Scotts, Michigan, was born January 1, 1879, at Pickerel Lake, Michigan. He graduated from the University of Michigan Medical School in 1903. Doctor Squiers took postgraduate studies in Pediatrics at the Harvard Medical School in

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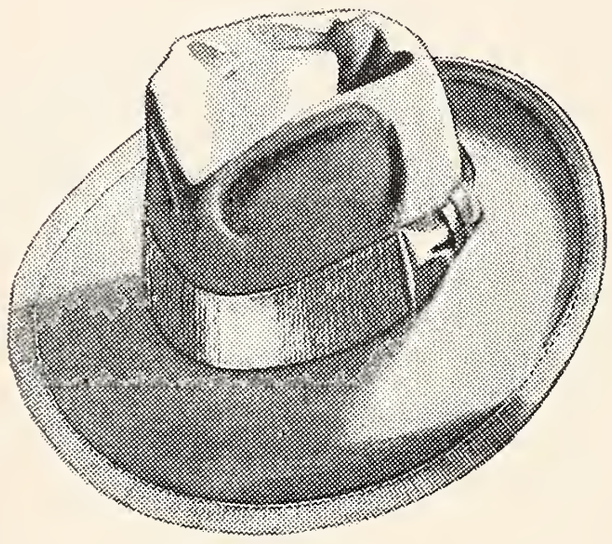
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1919-1920. He was a former member of the Kalamazoo County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Squiers passed on after a long illness on July 20, 1948, at Pickerel Lake, Michigan, at the age of sixty-nine years.

ROSS LUVERNE ZIMMERMAN, M.D., 15703 Ferguson, Detroit, Michigan. Dr. Zimmerman was born in Nebraska in 1885. He graduated from the Wayne University College of Medicine in 1924, and limited his practice to Roentgenology and Radiology. He was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Zimmerman died on May 23, 1948, in Detroit, Michigan, at the age of sixty-two years.

FOUNDATION PRIZE

The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of "The Foundation Prize." Authors of papers on obstetrical or gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, Secretary-Treasurer, 1259 Clifton Road, N. E., Atlanta, Ga.

UNIFORM CONTRACT READY FOR "HOME TOWN CARE" VETERANS PROGRAM

A uniform contract, to be used throughout the country in those states where voluntary, prepayment medical care plans are co-operating with the Veterans Administration in its "home town care for veterans" program, has been prepared and is now ready for signatures of Michigan Medical Service and similar organizations.

The contract is essentially the one which has been in force in Michigan since inception in January, 1946, of the "home town care" program for veterans in this state. It is based upon procedures tested by Michigan Medical Service during the last year which have resulted in the establishment of a uniform procedure for use by medical care plans providing "home town care" for veterans through co-operation with the VA.

The procedures used by Michigan Medical Service have proven to be simple, efficient and economical, and have been set up as an example to the other states in which the "home town care" program is operating.

Under the "home town care" program, veterans with service-connected disabilities may receive examinations and treatment from their own doctors. Doing away with all red tape, the program is simplified to six steps: (1) the veteran gets an authorization for examination and/or treatment from the Veterans Administration; (2) the veteran goes to the doctor of his choice; (3) he receives the necessary examination and/or treatment; (4) a report of the treatment or examination is sent by the doctor to Michigan Medical Service; (5) Michigan Medical Service pays the doctor; (6) the Veterans Administration reimburses Michigan Medical Service.

A total of 188,282 authorizations for examination and/or treatment of service-connected disabilities were issued to Michigan veterans under the "home town care" program between March 1, 1946, and August 1, 1948.

Say you saw it in the Journal of the Michigan State Medical Society

Communications

THE UNITED STATES JUNIOR CHAMBER OF COMMERCE

August 4, 1948

Dr. L. Fernald Foster, Secretary
Michigan State Medical Society
2020 Olds Tower
Lansing 8, Michigan

Dear Dr. Fern:

I want to express my heartfelt appreciation to you and the Michigan Medical Society for the support and co-operation given to my candidacy for the presidency of the United States Junior Chamber of Commerce. You have my assurance that during the coming year I will do all within my power to promote the highest standards of Americanism all over this country. To my way of thinking, this means developing the 180,000 members in the United States Junior Chamber of Commerce so that they become dynamic salesmen for those positive things in the American Way of Life that has made possible the highest standard of living and culture known to man. Private initiative, freedom of enterprise, freedom of opportunity, et cetera, will be emphasized as positive values.

Please accept my very sincere thanks and best wishes for the Michigan State Medical Society for the coming year and best wishes for you personally.

Sincerely yours,
PAUL D. BAGWELL, *President*
U. S. Junior Chamber of Commerce.

Editor Journal of the Michigan
State Medical Society

Dear Sir:

Due to an oversight, the name of the hospital in which the cases of osteochondritis dissecans were studied was omitted.

I would greatly appreciate your calling attention to the following change in paragraph 2 of the article on page 728, volume 47, July, 1948:

"Seven cases have been critically studied in Blodgett Memorial Hospital," instead of "in this hospital."

Very sincerely yours,
L. L. SWENSON, M.D.

WYANDOTTE GENERAL HOSPITAL

August 5, 1948

Wilfrid Haughey, M.D.
Editor, Journal of the
Michigan State Medical Society
Battle Creek, Michigan

Dear Dr. Haughey:

I have read with interest the annual report of the Committee of the Michigan State Medical Society on a

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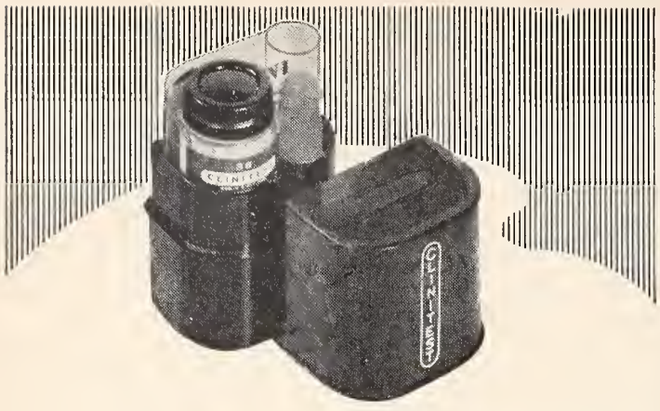
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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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Red Cross blood bank program for 1947-1948, as published in the July, 1948, issue of the JOURNAL. As an associate member of the Wayne County Medical Society, I have an interest in this matter somewhat beyond that which would naturally accrue to my position as administrator in this hospital. I take the liberty, therefore, of stating the position of this hospital with reference to the Red Cross medical practice activities.

In Denver, Colorado, and in San Francisco, California —to name but two of the several similar instances—the county medical societies and the hospital councils have collaborated to organize and operate full-time professional banks for whole blood, independent of the American Red Cross. These banks are entirely successful. I have just returned from the Second Midwest Institute for Hospital Administrators conducted by the American College of Hospital Administrators at the University of Colorado, at which I had the privilege of hearing a paper by Dr. Marion Rymer, director of Bonfils Memorial Blood Bank in Denver. Both in the paper mentioned and in the general discussion participated in by more than one hundred hospital administrators representing institutions from Ohio to California and from North Dakota to Texas, the thesis that the American Red Cross has no right to be in the blood bank business was strongly reiterated. Such activities on the part of the Red Cross institute an infringement upon good medical practice, an infringement upon sound hospital operation, and bring about a curtailment of efficiency in and a detriment to the general good of the communities concerned.

I note that in the report submitted by Dr. Morrish's committee, it is stated that "its (the American Red Cross) policy is to enter only those communities where it is requested to do so by the local medical society." Wyandotte is a community in which to my definite and positive knowledge this "policy" was not in effect. Less than a month ago, the American Red Cross came into this community for the purpose of collecting blood from our citizens, despite the fact that we, at the Wyandotte General Hospital, have an organized whole blood bank of several years' standing. No effort was made to contact the Southside Medical Society, a branch of the Wayne County Medical Society, or any member of the professional or administrative staff of this hospital prior to this invasion. When formal protests were lodged with the local management of the American Red Cross, it was observed that no reply from the Red Cross was received. The manager telephoned the present writer, but has refused to put himself on record in writing as to the Red Cross' position. Dr. Cooksey called upon the writer at the request of a member of the medical staff of this hospital and has stated that the activities of the Red Cross were apparently in conflict with its public relations policy. This, however, did not repair the damage done to our blood bank or ameliorate the confusion aroused in the minds of our local donors.

I am, of course, in no position to speak for any one but myself. It is of some interest to me, however, that thus far in a period covering more than eight months I have not found one qualified pathologist who was willing to give his professional support or blessing to the blood bank activities of the American Red Cross in this area.

Say you saw it in the Journal of the Michigan State Medical Society

I feel that in view of the threatened incursion of the Federal Security Agency, the Veterans Administration Facility, and other governmental or quasi-governmental agencies into the practice of medicine and the operation of hospitals, it is important for all of those who are concerned with the health and welfare of the general public to withstand the, to me, threatening activities of the American Red Cross in the blood bank field. To this end, I respectfully request that consideration be given to the publication of this letter.

Very sincerely yours,

PAUL CUSHING, *Administrator.*

NOVY ANSWERS EWING CHARGES

Answering the recent charge by Oscar W. Ewing, Federal Security Administrator, that "voluntary insurance plans cannot do the job" of aiding people to meet the costs of health services, R. L. Novy, M.D., President of Michigan Medical Service, pointed out that more than a million Michigan citizens are now enrolled in Michigan Medical Service.

The actual number of subscribers to Michigan's Blue Cross Plans, Michigan Medical Service and Michigan Hospital Service, is over 1,068,000 for the medical care plan and over 1,300,000 for the hospital care plan, Dr. Novy said.

The rapid growth of voluntary insurance plans in Michigan is reflected throughout the nation, he explained. There are now ninety voluntary hospital plans and ninety-two voluntary medical care plans in operation in forty-four states and the District of Columbia. The remaining four states have plans in the organization stage.

Over 40,000,000 people in the United States are protected against hospital costs, 31,210,819 by Blue Cross and the remainder by commercial plans. Approximately 30,000,000 people, or one-half the working population, are protected against loss of income due to disability, and over 17,000,000 persons receive surgical and medical protection through voluntary medical service and insurance plans, Novy declared.

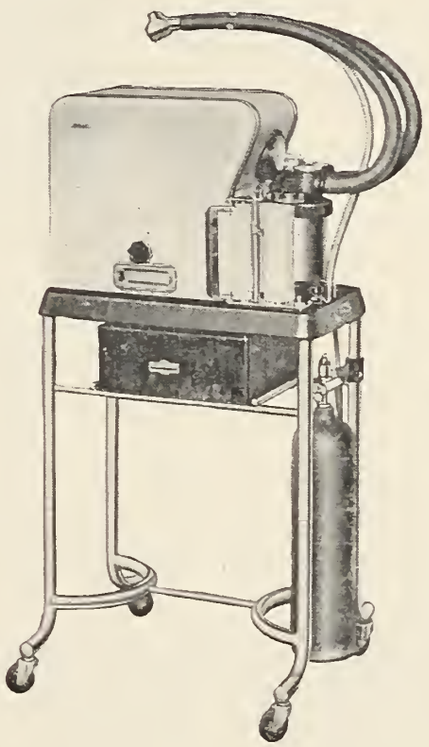
"Considering the fact that the Blue Shield (Blue Cross in Michigan) type of voluntary prepayment medical care plans alone have grown from 700,000 subscribers in 1942 to 8,702,911 as of June 30, 1948, and with the corresponding increase by commercial plans, it is doubtful that meeting this need the American way can be lightly brushed aside by politicians anxious to hold their jobs for another four years," according to L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society. "The would-be socializers of American medicine cannot hope to do the job that the health professions are accomplishing in a voluntary way."

It was predicted by Dr. Novy that on the basis of the current rate of growth over the last eighteen months there will be 10,000,000 subscribers to medically-sponsored voluntary medical service plans by the end of 1948.

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. . . . . NEWS MEDICAL

Gordon K. Moe, M.D., Ann Arbor, is the author of an original article "Potentiation of Action of Epinephrine" which appeared in JAMA of July 24.

* * *

Dave B. Ruskin, M.D., Caro, Michigan, is the author of an original article "Dermatitis Bullosa due to Mesantoin" which appeared in JAMA of July 17.

* * *

W. B. Cooksey, M.D., and G. C. Puschelberg, of Detroit, are co-authors of an original article entitled "Disposable Fine Mesh Filter For Blood and Plasma" which appeared in JAMA of June 26, 1948.

* * *

John E. Summers, M.D., and W. C. Reid, M.D., of Goodrich, are authors of an original article "Hodgkin's Disease Complicated by Pregnancy" which appeared in JAMA of June 26, 1948.

* * *

C. E. Badgley, M.D., and R. H. Denham, M.D., Ann Arbor, are authors of an original article "Aseptic Necrosis of the Femoral Head" which appeared in JAMA of July 31.

* * *

Samuel J. Nichamin, M.D., Detroit, is the author of an original article "Stokes-Adams Syndrome Associated with Complete Congenital Heart Block in Infancy and Childhood" which appeared in *Pediatrics,* March 1948.

* * *

Charles F. Wilkinson, M.D., Ann Arbor, is the author of an original article entitled "The General Practitioner" which appeared on page 945 of the July 10 number of JAMA.

* * *

Samuel D. Jacobson, M.D., Lawrence Berman, M.D., Arnold R. Axelrod, M.D., and Elmore C. vonder Heide, M.D., Detroit, are authors of an original article "Folic Acid Therapy" which was published in JAMA of July 3, 1948.

* * *

C. R. Dengler, M.D., Jackson, has been appointed a member of the Committee from Michigan to arrange the 1950 White House Conference on Children, according to advice from Governor Kim Sigler. Congratulations, Dr. Dengler!

* * *

The Muskegon County Medical Society features on the cover of its monthly *Bulletin* one of its own members. In the body of *The Bulletin* a thumbnail sketch of the honored physician is given in a column named "Orchids to the Living." Recent men selected were R. J. Douglas, M.D., V. S. Laurin, M.D., and E. S. Thornton, M.D.

Thomas Francis, Jr., M.D., Gordon C. Brown, Sc.D., and Lawrence R. Penner, Ph.D., of Ann Arbor, are authors of an original article entitled "Search for Extrahuman Sources of Poliomyelitis Virus" which appeared in JAMA of April 24, 1948.

* * *

A.C.P.—A preliminary program of postgraduate courses arranged by the American College of Physicians for the autumn of 1948 has been received by MSMS. For copies, write Executive Secretary, E. R. Loveland, 4200 Pine Street, Philadelphia 4, Pa.

* * *

Federal Funds: During the present fiscal year, Michigan expects to receive $42,000,000 from the U. S. for such purposes as public health activities, and social security and education. These funds, for the most part, must be matched by the state—Michigan Survey of July 26, 1948.

* * *

World Medical Association.—Any member of the Michigan State Medical Society may become a Founder Sustaining Member of the World Medical Association by sending membership dues of $10.00 to Lewis H. Bauer, M.D., 2 E. 103rd St., Hempstead, N. Y., Secretary-General. The WMA, founded in Paris in 1947, has the full approval of the American Medical Association.

* * *

E. F. Sladek, M.D., Traverse City, President-Elect of the Michigan State Medical Society, was chosen Chairman for the ensuing year of the Associated States Postgraduate Committees, at its meeting in Chicago on June 23. *Leroy Parkins, M.D.,* Boston, was made Vice Chairman, and *H. H. Cummings, M.D.,* Ann Arbor, MSMS Past President, was selected as Secretary-Treasurer. Congratulations, Doctors Sladek and Cummings.

* * *

The Belgium Medical Federation is in revolt against a fiscal notebook to be kept by the physicians for fees of insured patients. A fee should be indicated by persons who are subject for insurance against diseases. Of the 8,000 practitioners, 6,000 have declared themselves ready to co-operate in not using the fiscal notebook. They will not fill out any administrative papers, except medical prescriptions on personal stationery, testimony for the civil and criminal laws, and reports of contagious diseases.

* * *

"Health for the American Worker" will be the theme of the next annual Congress on Industrial Health, which will be held in Chicago early in 1949 under the sponsorship of the American Medical Association. There will be a two-day session broken up into four principal panels, Indus-

(Continued on Page 1036)



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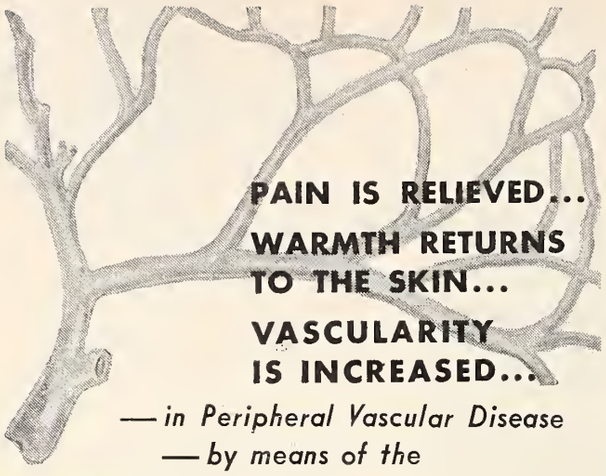
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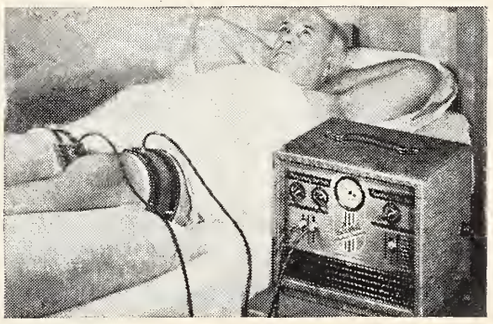
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(Continued from Page 1034)

trial Health, Medical Service, Health Education, and Preventive Medicine and Public Health. This program will fill a gap left by the National Health Assembly held in Washington last May.

* * *

The American College of Chest Physicians is sponsoring three postgraduate courses in the latest developments of Diseases of the Chest. Each course is of one week's duration, open to all doctors of medicine—tuition fee $50.00 per course, limited to fifty physicians each. The courses will be given in Chicago, September 20-25, in New York City, November 8-12, and in San Francisco, September 13-17. For further information write the College at 500 N. Dearborn St., Chicago 10.

* * *

Orientation in Allergy.—Almost every practitioner of medicine, whatever his field, is bound to encounter allergic problems in his practice. Most of the practising physicians have had little if any opportunity to obtain the basic knowledge concerning allergy while they were medical students. To remedy in part this deficiency and to provide the demand for an up-to-date coverage of the field of allergy, Northwestern University Medical School and the American Academy of Allergy are offering an orientation course in allergy to be given during the week of October 25 to 29, inclusive. This course is thorough, and the faculty includes many men of national prominence.

* * *

Medical Training Costs Money—What is the cost of becoming an M.D. these days? . . . The magazine "Medical Economics" says it costs not less than $32,000 to become a physician, calculated as follows: pre-medical training, $7,000; medical education, $7,000; an earning loss of $15,000 for six years while in training; and an investment of at least $3,000 in equipment when starting practice. This enormous investment, undoubtedly greater than for any other vocation, constitutes one of many good reasons why the practice of medicine must be kept free of political interference if it is to continue to attract a high grade of young men and women into its ranks.—Membership News Letter, The Medical Society of New Jersey, August 1948.

* * *

The New National Health Service of Great Britain went into effect July 5, 1948. Under this scheme the total maximum fees for a specialist or surgeon holding a particular time appointment will be $8,000 a year. This may be made up by the cession of $800 a year paid for a half day of each week at a hospital or clinic, and there may not be more than eight such cessions.

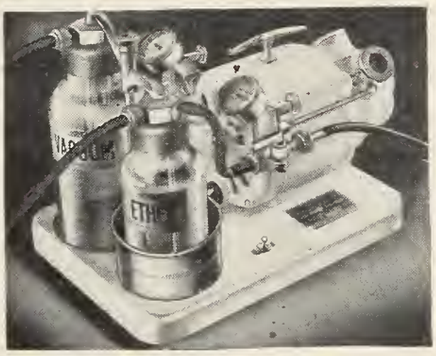
If a physician is called in consultation by a general practitioner in the patient's home, he will be paid at the rate of $400 every three months for twenty-five such consultations, and he may not be paid in excess of twenty-five consultations.

For minor surgery in the patient's home, the pay will be $21. The salaries recommended for specialists appointed to the staff of hospitals at age thirty are below

(Continued on Page 1038)

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(Continued from Page 1036)

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* * *

Five AMA Officers left for Tokyo on August 1, at the invitation of General MacArthur and Brig. Gen. Crawford W. Sams as an advisory committee to consider all phases of Japanese medical problems. The officers included President R. L. Sensenich, M.D., President-Elect Ernest E. Irons, M.D., Trustees Chairman Elmer L. Henderson, M.D., E. J. McCormick, M.D., and J. H. Fitzgibbon, M.D., members of the Board of Trustees. In reporting this trip, AMA Secretary George F. Lull, M.D., writes: "Established law and custom in Japan may call for a different solution of some of the complex medical problems. But our stand has been that we, as a medical profession, do not want any new ideas forced on the Japanese people that we ourselves would not be willing to accept."

* * *

"Visiting Chiefs" at Atlantic City.—Each week during the late spring, summer, and early fall, the medical service at the Atlantic City Hospital (New Jersey) has a "Visiting Chief" in the person of some distinguished physician who is visiting Atlantic City. These Visiting Chiefs play a prominent part in the intern and resident training program of the hospital, presiding at meetings at 4:30 p.m. each Tuesday and Friday afternoons, offering presentations at these clinics, conducting clinical-pathological conferences, et cetera. Among the prominent physicians who have visited Atlantic City Hospital this spring in this capacity are Dr. Jonathan C. Meakins of McGill University School of Medicine, Dr. Garfield G. Duncan of Jefferson Medical College, Dr. Wingate Johnson of North Carolina; Dr. Tom Kain, Chief of Medical Service of Cooper Hospital in Camden; Dr. H. B. Mulholland of the University of Virginia, and Dr. M. C. Pincoffs of the University of Maryland.

Among those scheduled to take part in the program during the rest of the year are Dr. Regionald Fitz of Harvard, Dr. Louis H. Bauer, Executive Director of the World Medical Association, Dr. Thomas Durant of Temple, Dr. Hobart Reimann of Jefferson, Dr. Edward Weiss of Temple, and Dr. Fred Lathrop, Governor for New Jersey of the American College of Physicians.

* * *

Another Mission to Japan.—Several months ago, General MacArthur had a group of consultants advising him on all phases of the Japanese Social Security system, including sickness insurance. At the time the consultants were appointed, the American Medical Association voiced disapproval because it felt that the consultants were largely employed by, or connected with, groups in this country which believe that compulsory sickness insurance is the only way of solving our medical problems.

Brig. Gen. Crawford W. Sams, chief of the medical branch of the Civil Affairs Division in Tokyo, recently

(Continued on Page 1040)

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(Continued from Page 1038)

sent a complete copy of the consultants' report for analysis by the AMA. He also suggested that the AMA appoint a committee of qualified physicians, who could meet with the consulting staff in Japan and go over the entire situation with them.

As a result, five officers of the AMA—President R. L. Sensenich, President-Elect Ernest E. Irons, Dr. Elmer L. Henderson, chairman of the Board of Trustees, and Dr. E. J. McCormick and John H. Fitzgibbon, members of the Board of Trustees—left by air for Tokyo, Sunday, August 1.

Established law and custom in Japan may call for a different solution of some of the complex medical problems. But our stand has been that we, as a medical profession, do not want any new ideas forced on the Japanese people that we ourselves would not be willing to accept.

* * *

Change Method of Selecting General Practitioner.—With more and more attention being directed to the second annual AMA Interim meeting to be held in St. Louis, Nov. 30 to Dec. 3, 1948, attention is called to the resolution, adopted by the House of Delegates at the Chicago session in June, changing the method of selecting the outstanding general practitioner of the year. The selection is made at the Interim Session.

The resolution, which was introduced by Dr. E. S. Hamilton in behalf of the Illinois State Medical Society, set out that the first award was made at the AMA meeting in Cleveland last January, but was "marred by confusion and misunderstanding." The resolution said it was desirable to set up some definite procedure for the selection of the AMA general practitioner of the year, recommending that the selection originate at the county society level and proceed through state organizations so that local or state groups and individuals may pay tribute to the family physician of their choice.

The resolution set in operation the following plan:

1. Each county medical society shall be urged to name the candidate of its choice as the outstanding general practitioner for the year within its jurisdiction, basing its selection on nominations and recommendations from any responsible source, lay or professional.

2. The name of each candidate so chosen by a county medical society, with all pertinent data, including recommendations of lay groups and individuals, shall be submitted by the county medical society to the state medical society of which it is a component part.

3. Each state medical society, through whatever agency each may designate, shall select from among the candidates submitted by its component county medical societies one name to be declared the outstanding general practitioner within the state.

4. The candidate so selected at the state level shall be the sole candidate from that state, and his or her name, with all pertinent supporting data, shall be submitted to the Board of Trustees of the American Medical Association.

(Continued on Page 1042)

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(Continued from Page 1040)

5. The Board of Trustees shall select from the names submitted by state societies the names of three persons, these names to be submitted in turn to this House of Delegates, which shall select one name to be declared the outstanding general practitioner of the United States for the year.

6. Any state medical society desiring to do so may establish and confer a suitable award with fitting public ceremony on the physician it has named as the outstanding general practitioner of that state for the year.

* * *

Resolution on Cancellation of Contract with Commercial Insurance Company.—At the 1948 Session of the AMA House of Delegates in Chicago, June 21-25, L. G. Christian, M.D., Lansing, on behalf of the Michigan State Medical Society, presented the following resolution:

"WHEREAS, The American Medical Association on many occasions has encouraged the formation of nonprofit voluntary prepayment hospitalization and medical service plans by its constituent state and county societies; and

"WHEREAS, These constituent state and county societies have participated in the formation and development of nonprofit voluntary hospitalization programs (nationally known as Blue Cross hospitalization plans); and nonprofit medical surgical service programs (nationally known as Blue Shield plans); and

"WHEREAS, The action of the American Medical Association in canceling its contract with the Chicago Blue Cross which provided hospitalization for the employes of the American Medical Association and in contracting with a commercial insurance company for the same coverage was not in the best interest of the medical profession as a whole or the voluntary Blue Cross and Blue Shield plans; and

"WHEREAS, This action of the American Medical Association has already by adverse publicity caused serious embarrassment to the Blue Cross and Blue Shield plans; and

"WHEREAS, Both Blue Cross and Blue Shield plans are available in Chicago; therefore be it

"RESOLVED, That the House of Delegates of the American Medical Association instruct its Board of Trustees to cancel the contract with the commercial insurance company at the earliest possible time and obtain contracts with the Blue Cross and Blue Shield plans to cover their employes."

The report of the Reference Committee on Medical Service and Prepayment Insurance contained the following information and recommendation:

"Your committee is of the opinion that because the American Medical Association has sponsored and encouraged the development of nonprofit voluntary prepayment hospitalization and medical service plans that the discontinuance of Blue Cross Hospital Service for its employes has reacted unfavorably to the nonprofit voluntary prepayment hospital and medical service philosophy and, likewise, unfavorably to the interest of plans developed by the various state and county medical societies throughout the country.

"However, your committee is of the opinion that circumstances and conditions prevailing at the time the present insurance contract was entered into were such that this action was thought to be in the best interests of the employes of the American Medical Association.

"Your committee recommends because of the above-stated opinions that at the expiration of the present contract of hospital and medical health coverage the American Medical Association, through its proper officials, make every sincere effort to procure this coverage for its employes through Blue Cross-Blue Shield local organization. The committee understands that this coverage is and will be available."

* * *

COMPREHENSIVE UNIT COURSE IN PATHOLOGY

A new comprehensive unit course is to be initiated in pathology with the opening of school in September at the College of Medicine, Wayne University, Detroit. It is designed to fill the needs for work in pathology of graduate medical students in the clinical specialties. Although

the actual instruction offered is comparable to the usual twelve months hospital residency in pathology, the full schedule of supervised instruction and the elimination of administrative detail permit the reduction in time to the academic year of nine months (thirty-six weeks).

The enrollment is limited in 1948-49 to five, and these five will be selected from applicants who have had a one-year rotating internship and on the basis of experience and scholastic record. State Board Registry is not necessary.

This is a comprehensive graduate course in pathology, using materials and methods of instruction generally followed in the teaching of Residents and Fellows. Demonstrations and supervised examination of gross and histologic material and conference table discussion supplemented by library research will receive principal emphasis. Correlation between clinical findings and lesions will be stressed. The curriculum is built largely around an ample supply of current autopsy and surgical material.

MICHIGAN MEDICAL SERVICE TO RECEIVE AWARD

Michigan Medical Service will receive a signal honor on October 27 when it will be presented with a special award from Associated Medical Care Plans, the national organization of voluntary non-profit prepayment plans for medical care.

The award will be made by General Paul R. Hawley, Chief Executive Officer of Associated Medical Care Plans, and L. H. Schriber, M.D., President of the Association, at the annual meeting at French Lick Springs. R. L. Novy, M.D., President of Michigan Medical Service, and Jay C. Ketchum, Vice President of the organization, will accept the presentation.

Described by United States Senator Arthur H. Vandenburg as "Michigan's greatest public trust" created by the medical profession, Michigan Medical Service will receive the award because it is the first medically sponsored prepayment plan in the United States to enroll more than a million members.

Organized in March, 1940, Michigan Medical Service was the result of intensive study and investigation by the Michigan State Medical Society and county medical societies in the state. The studies included an examination of the British Panel System by representatives sent to England for that purpose. It was necessary to secure enabling legislation in order to put the program into operation, and this legislation was passed during 1939 and Michigan Medical Service began operation on March 1, 1940.

Now the largest medical care plan in the country, it has developed, during its brief history, procedures which have been accepted as a pattern for many other plans now operating or being organized.

$10,200,800,000 has been paid into the Social Security Administration in 11 years and $849,000,000 collected in interest. Benefits paid total $1,689,600,000 and administrative cost $246,000,000. The kitty remaining is over NINE BILLION. Where do you suppose it is?



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Surgical Anatomy and Clinical Surgery, two weeks, starting September 27, October 25, November 22.
Surgery of Colon and Rectum, one week, starting October 18, November 15.
Surgical Pathology every two weeks.

FRACTURES AND TRAUMATIC SURGERY—Intensive Course, two weeks, starting October 25.

GYNECOLOGY—Intensive Course, two weeks, starting October 11.
Vaginal Approach to Pelvic Surgery, one week, starting October 25.

OBSTETRICS—Intensive Course, two weeks, starting October 25.

UROLOGY—Intensive Course, two weeks, starting September 27.

MEDICINE—Intensive Course, two weeks, starting October 11.
Personal Course in Gastroscopy, two weeks, starting September 27, November 8.
Gastroenterology, two weeks, starting October 25.
Hematology, one week, starting October 4.

DERMATOLOGY—Formal Course, two weeks, starting October 4.
Clinical Course every two weeks.

OPHTHALMOLOGY—Intensive Course, two weeks, starting September 20.
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OTOLARYNGOLOGY—Intensive Course, two weeks, starting October 18.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

ECONOMIC MAN IN RELATION TO HIS NATURAL ENVIRONMENT. By C. Reinold Noyes. In two volumes. Price $15.00. New York-Morningside Heights: Columbia University Press, 1948.

This is an impressive scheme of basic human motivation. It is a vast scientific study of the human being, what makes him work, how he works, and why, with special emphasis on "why." Evidence is deduced from all scientific journal literature. The author counters Descartes, Calvin, Huxley. He criticizes the theories of reflexology, pain-pleasure motivation, instinct theory, the marginal utility school of thought, the system founded upon the three economic "factors" of land, labor and capital, the idea of opportunity costs, the scarcity theory, and "the notion that human beings allocate their resources so as to produce an equilibrium between cost and satisfaction at the margin of each incomplete satisfaction." The author spent seventeen years in research preparing this book, and has given 200 pages of direct quotation, supporting the material on central mechanisms for generating behavior. This is a book on pure and classical philosophy as applied to human behavior, and cannot be ignored by the student and the psychiatrist.

HEART: A PHYSIOLOGIC AND CLINICAL STUDY OF CARDIOVASCULAR DISEASES. By Aldo A. Luisada, M.D., Instructor in Physiology and Pharmacology, Tufts College Medical School, and Lecturer in Medicine; Lecturer, Postgraduate Division. Tufts College Medical School; Associate in Medicine, Beth Israel Hospital, Boston, Mass.; Former Professor of Medicine, Ferrara, Italy. With a Foreword by Herman L. Blumgart, Physician-in-Chief, Beth Israel Hospital; Professor of Medicine, Harvard Medical School. Baltimore: The Williams & Wilkins Co., 1948. Price $10.00.

There has been such great advancement in knowledge of cardiology in the last few years that another survey seems timely. The author of this book has written it primarily for the general doctor, but so as to be of value also to the cardiologist. The terms are general, the classification of diseases based more upon pathology than upon etiology. Tracings of the heart sounds and vibrations are minutely studied. Laboratory procedures are used, rheumatic fever evaluated and endocardial diseases given their place. Defects, shunts, malformations and disturbances of rate and rhythm get full attention. The new work on Fallot's tetrology, Blalock's surgery, is given full recognition. The whole book is authoritative, very clear, and warrants full study.

CLINICAL OPHTHALMOLOGY FOR GENERAL PRACTITIONERS AND STUDENTS. By H. M. Traquair, M.D., F.R.C.S., Ed. Consulting Ophthalmic Surgeon, Royal Infirmary, Edinburgh. Ophthalmic Surgeon, Chalmers Hospital, Edinburgh. Oculist to the Edinburgh Municipal Hospitals. Late Lecturer on Diseases of the Eye, Edinburgh University. With 72 illustrations including 8 coloured plates. The C. V. Mosby Co., St. Louis, 1948. Price $9.00.

This is an English book written for the use of students or practitioners who are not familiar with most of the technical instruments. It gives directions and instructions for making a diagnosis, and warns when such a case should be sent to a specialist. Good colored picture help to make decision. One thing mentioned as a foreign body

to be expected in rural districts is the "barley awn"—husk of a barley grain. The chapter on glaucoma is complete, and modern. Visual paths and fields of vision are clearly outlined and meanings given. A very useful book for the non-specialist.

MEDICAL WRITING—The Technic and the Art. By Morris Fishbein, M.D., Editor, The Journal of the American Medical Association, with the assistance of Jewel F. Whelan, Assistant to the Editor. Second edition. Philadelphia: The Blakiston Company, 1948. Price $4.00.

Dr. Fishbein has largely rewritten his book, and as always stresses exact expression, using the precise word to give the meaning intended. He illustrates with many words the common usage and the correct word or expression. He gives many rules of selection, such as the word twofold, without the hyphen. Also when a proper name is used as an adjective, the name is still capitalized. The preparation and use of illustrations is given detailed attention. Proofreading is made clear, in correct form for the printer. This book is a single but exact and valuable outline for the use of newcomers to the writing field, and is a stimulus to the old hand who may gain some valuable help.

TWENTIETH CENTURY SPEECH AND VOICE CORRECTION. Edited by Emil Froeschels, M.D., President, International Society for Logopedics and Phoniatrics; President, New York Society for Speech and Voice Therapy. New York: Philosophical Library, 1948.

Requested by the publisher, this volume has been produced to give students and, especially, voice teachers a guide for voice training and cultivation. The anatomy and physiology of sounds and letters or word formation is given. Certain forms of defects are defined as "aphasia," "Paragrammatism," "Alalia." Causes and methods of correction are given, and the effect of cleft palate gets special attention. A final chapter is devoted to training the voice after laryngectomy. There are nineteen contributors to the book, each writing his own section. In all, a worth-while book.

RECENT ADVANCES IN SURGERY. By Harold Edwards, C.B.E., M.S., F.R.C.S., Surgeon and Lecturer in Surgery, King's College Hospital, London; Surgeon, Evelina Hospital for Sick Children; Dean, Medical School, King's College Hospital; Former Consulting Surgeon, Central Mediterranean Forces. Philadelphia: The Blakiston Company, 1948. Price $6.50.

The progress of surgery in all its varied branches has been well nigh immeasurable during the past decade. This is a book for the surgeon, the general physician and many specialists interested in the important advances in certain fields. Many eminent workers have collaborated in the preparation of this edition, resulting in the production of an invaluable guide and reference work to the really new developments. Treatment of cardiac pain, blood transfusion, water balance, burns, postoperative pulmonary complications, anesthesia, aseptic anastomosis, vagotomy, physiological gastrectomy, Banti's disease, intravenous clotting, vascular injuries, ductless gland, are a few of the subjects that have been given special attention. There are many unusual illustrations in the book.

OUTLINE OF PHYSIOLOGY. By William R. Amberson, Ph.D., Professor Physiology, University of Maryland, and Dietrich C. Smith, Ph.D., Associate Professor Physiology, University of Maryland. Illustrations by the late Norris Jones, Instructor in Scientific Illustrating, Swarthmore College, and William Loechel. Second edition. Baltimore: The Williams & Wilkins Co., 1948.

The fields of related subjects which collectively form biology, according to these authors, is getting very extensive, and new frontiers are continually being established. Therefore, limitations must be made, and physiologists find it necessary to keep abreast of more than their own science. This volume has been prepared with particular consideration of the student and younger persons just entering the field of science. The contents of the book are divided into sections on the Living Cell, Basic Phenomena of Life, Nervous Integration of Physiological Function, Circulation, Respiration, Metabolism, Digestion, The Endocrine Glands, Reproduction. Each subject is given a full and detailed account. The book is arranged two columns to a page, is well printed and is an authoritative study and reference.

HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA. Part II. 1833-1944. History Committee: John Benjamin Nichols, Chairman; William Johnston Mallory, Joseph Stiles Wall, Washington, D. C. Baltimore: Waverly Press, Inc., 1947.

This history gives an introduction of the organization, with notes and a list of members. The historical sketch tells of the two societies and their amalgamation. Fee schedules, contract practice consultations, public health, medical education are all mentioned. The main feature for the last decade is economics. About half of the book is taken up by lists of members during the early years and of the later society. This is a historical record and, as such, has a distinct value.

PRINCIPLES GOVERNING EYE OPERATING ROOM PRACTICES. By Emma I. Clevenger, R.N., Supervisor, Eye Operating Room, New York Eye and Ear Infirmary, New York City. Illus. St. Louis: C. V. Mosby Company, 1948. Price, $5.50.

This book is composed strictly of outlines and lists. It describes and illustrates eye instruments, describes terms, lists operations and the instruments used. Many pictures are given of typical setups. Tables and photographs for caring for eye instruments and equipment, electrical apparatus, sutures, linens, syringes are given. This is an exact guide for the nurse or doctor whose responsibility is to prepare for eye surgery.

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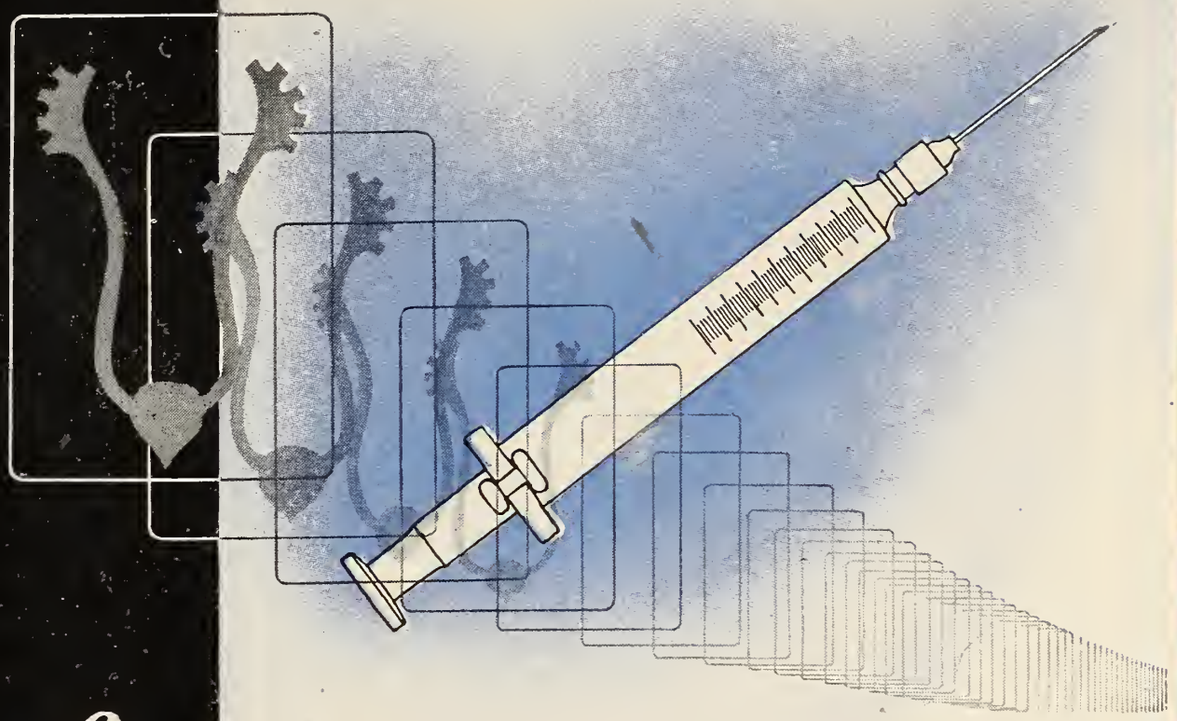
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(Continued from Page 1010)

with Horner's syndrome (contraction of the pupil, narrowing of the palpebral fissure, recession of the eye and loss of sweating of the face and neck on the affected side).

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

August 18, 1948

- Monthly financial reports and bills payable were presented, studied, and approved.
- The Executive Committee of The Council approved the appointment of an MSMS Committee to meet with representatives of the American Heart Association to discuss the Michigan heart and rheumatic fever program and future co-operation with the AHA; it also approved the formation of a Michigan Heart Association with the hope that it may become an affiliate of the AHA, and it empowered the MSMS President to appoint an organization committee to form a Michigan Heart Association as soon as possible.
- Reports accepted from Committee on Second Rural Health Conference (held on Campus of Michigan State College, East Lansing, September 16-17, 1948), and from Mental Hygiene Committee.
- "Lucky Junior," the MSMS motion picture, is being distributed to all Michigan theaters during September and October, 1948.
- "Medical Associates" brochure, now in type, will be ready for distribution to MSMS House of Delegates on September 20.
- AMA radio program. The Public Relations Counsel was authorized to co-operate with the AMA in connection with its new national radio program.
- Eugene A. Osius, M.D., Detroit, accepted appointment as Councilor of Sixteenth District (Wayne County).
- The Veterans Administration's proposed hospital in Ann Arbor was discussed and resolution, to be presented to MSMS House of Delegates on September 20, was reviewed. A letter on this subject was authorized to be sent to the Board of Regents of the University of Michigan.
- Appointments to the Committee on Program and Arrangements for the third Michigan Postgraduate Clinical Institute, scheduled for Book-Cadillac Hotel, Detroit, March 23-24-25, 1949, were presented and confirmed.
- The new intramural postgraduate course in cancer, to be presented by the MSMS Committee on Postgraduate Medical Education, was approved and referred to Dr. L. Fernald Foster for publication in the Secretary's Letter to county medical society officers.
- The Executive Committee of The Council appointed G. Thomas McKean, M.D., Detroit, R. C. Pochert, M.D., Owosso, and B. R. Van Zwaluwenburg, M.D., Grand Rapids as MSMS representatives to the Conference on Tuberculosis Case Finding, sponsored by the Michigan Tuberculosis Association, held September 9 in Lansing.
- A. Hazen Price, M.D., was appointed the MSMS representative to the Department of Public Instruction as Advisory Committee on the Michigan Practical Nurse Training Program, for the year ending June 30, 1949.
- C. G. Clippert, M.D., Grayling, E. G. Merritt, M.D., Detroit, and O. B. McGillicuddy, M.D., Lansing, were appointed as MSMS representatives to three committees of the Michigan Nursing Center Association, upon invitation of that organization.
- A proposed bill on Vocational Rehabilitation, developed by the State Rehabilitation Office, and proposed amendments to the Michigan Social Welfare Act of 1939, developed by the Michigan Hospital Association, were referred to the MSMS Legislative Committee.

ANSWERS TO THE CRITICS

What has been the growth in medical schools and in medical graduates?

This is indicative:

In 1920, 85 schools in U. S. had 13,798 students and graduated 3,047.

In 1946, 77 schools in U. S. had 23,216 students and graduated 5,826.

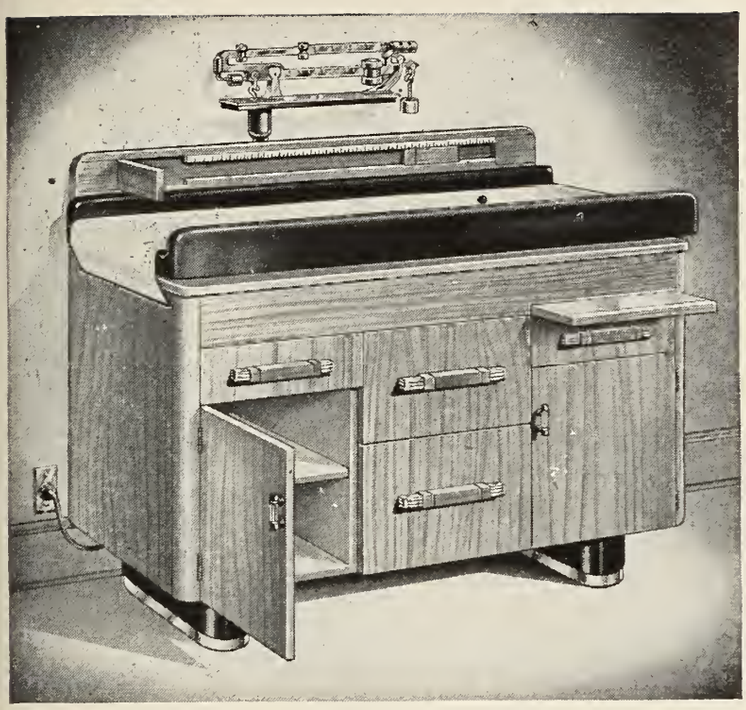
What has been the growth in the total number of physicians?

In 1890 there were 100,180 physicians and a population of 629 per physician.

In 1948 there were 200,000* physicians and a population of 760 per physician.

*Estimated.

(Continued on Page 1058)



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Say you saw it in the Journal of the Michigan State Medical Society

ANSWERS TO THE CRITICS

(Continued from Page 1056)

How does the supply of physicians in the United States compare with that of other countries?

In the United States there is one physician to 760 people. Compare this with the latest pre-war statistics which show that:

In Great Britain there was about 1 physician to 1,100 people.

In Germany 1 physician to 1,300 people.

In France 1 physician to 1,600 people.

In Sweden 1 physician to 2,700 people.

In Yugoslavia 1 physician to 3,400 people.

REBATES

The Council of the Wayne County Medical Society, on September 10, 1948, adopted the following statement re rebates:

"The Wayne County Medical Society clarifies its stand and disapproves as unethical rebates, resale for profit, or 'kickbacks' on any commodity used in rendering medical service.

"The Council of the Wayne County Medical Society is asking for the co-operation of every member in the reporting of any infraction to the Ethics Committee.

"On request, the statement to the patient should show all the transaction. The Ethics Committee in its report to the Council will use as its guiding principle what is for the protection of and best for the patient.

"As previously stated, removing hidden compensation probably will not reduce the cost of medical care."

ECONOMIC LESSON

The year 1939 was a traditional one. And prices were historically related to each other. Where are they now? This is what BAE and BLS figures show:

1939 being 100:			
Farm prices	281	Construction costs	190
Prices farmers pay	196	Stock prices	126
Factory labor	226	Rents	116
Retail Food	214	Textiles	222
		Fuels	177

—*Nation's Business*

EMPLOYER BENEFITS

In the not too distant future your business will be a rare one, if it doesn't include some sort of employe benefits.

They're spreading fast.

Today 1,250,000 workers are covered by some type of health-benefit plans negotiated by companies and unions. That's up from 600,000 in 1945.

Health, welfare, retirement benefit plans of all types now cover 3,000,000 workers. They exist in 100 national or international unions.

More workers' unions become interested in these benefits as they see wage boosts gobbled up by rising living costs.

Trend is to liberalize, increase number of benefits.—*Nation's Business.*

Last year more was paid on taxes than was spent all told on homes, cars, furniture, religious and charitable donations, private education, medical care and funerals. *Nation's Business.*

In the past ten years medicine has made the greatest advance in its history toward assuring men and women everywhere the Biblical life span of threescore years and ten.—*Nation's Business.*

ASSOCIATED MEDICAL CARE PLANS NEWS

EDITOR'S NOTE.—There has been much misinformation and mistrust about the national sales and service plans of the Blue Cross and Blue Shield. This has led to misunderstanding and delay of necessary programs. A meeting was held in Los Angeles March-April to bring about a working agreement, and much progress was made, but a group representing several states demurred, and called an independent session. In June the Council on Medical Service of the American Medical Association called a meeting of representatives of the State Medical Societies "to consider the proposed merger of Blue Cross and Blue Shield." As a result of both these protest meetings it was decided to make further studies of the proposed National Service plans and report back. The following information is a summary of what has been accomplished.

Important Proposals Submitted to Blue Cross and Blue Shield

Revised proposals for the establishment of a Blue Cross-Blue Shield Association and a Blue Cross-Blue Shield Health Service, Inc., were submitted to all Blue Cross and Blue Shield Plans on September 10, having been approved by the Blue Cross and Blue Shield Commissions, respectively, at their meetings in Chicago on August 20.

Formal presentation and action on these proposals is scheduled for October 25-28 when Blue Cross and Blue Shield Plans will hold their annual meetings at French Lick Springs, Indiana.

Also ordered by the Blue Shield Commission at its last meeting was the referral of the proposals to the Council on Medical Service of the American Medical Association for discussion at their meeting on September 30.

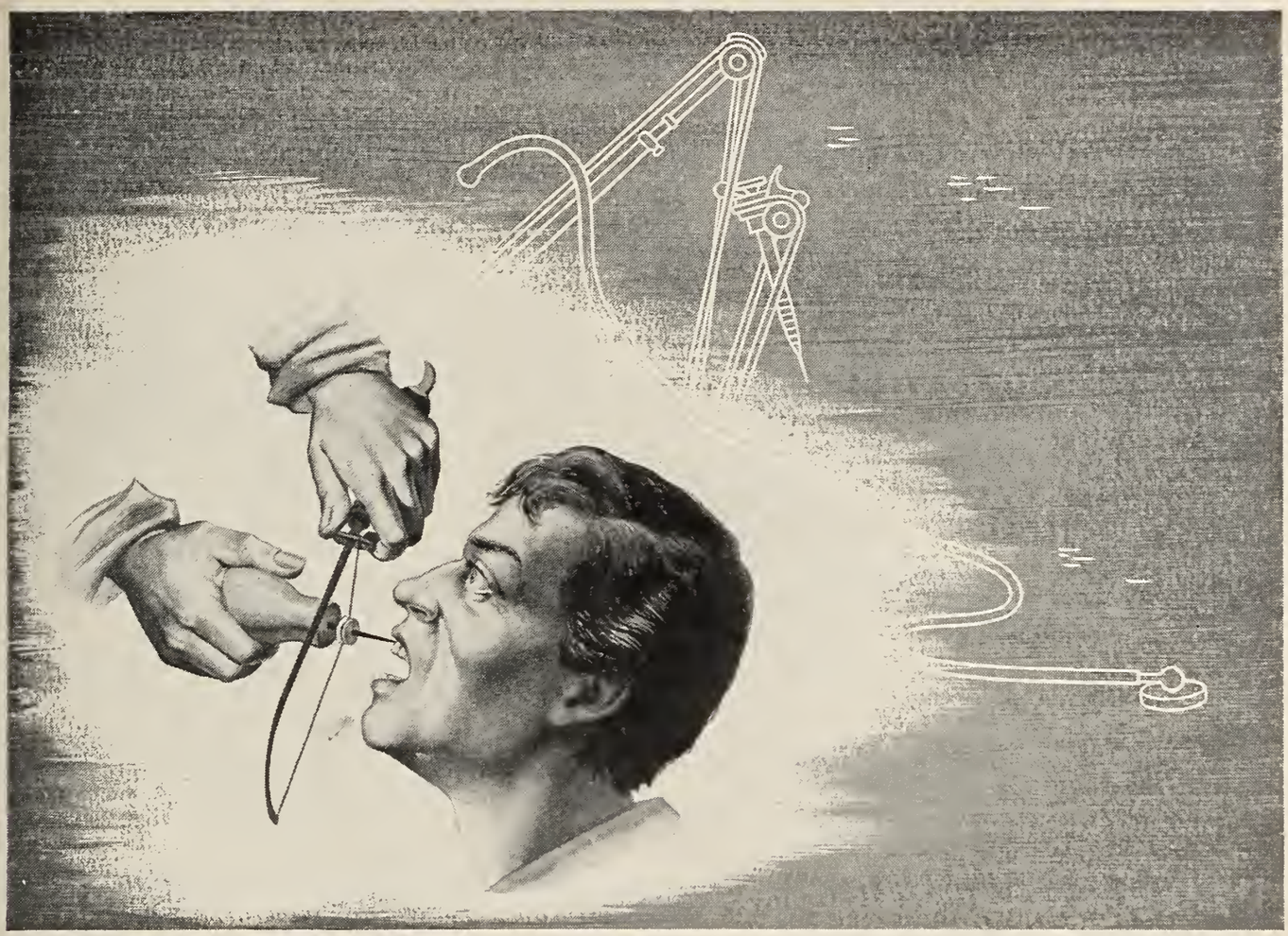
Originally presented at the 1948 Semi-Annual Conference of Blue Cross and Blue Shield Plans in Los Angeles last April, the present proposals have been revised considerably in order to meet objections raised at that time.

The Blue Cross-Blue Shield Association does not constitute a proposed merger of the two movements, but a corporate device whereby members of the Blue Cross and Blue Shield Commissions would be incorporated as an Association for administering certain delegated functions of mutual concern to both groups.

The creating of a national enrollment agency to serve Blue Cross and Blue Shield equally is among the chief purposes for which the Association would be formed.

"The national agency is not being proposed for the purpose of making Blue Cross and Blue Shield bigger . . . to have them cover more people," explained Dr.

(Continued on Page 1060)



The First Modern Dentistry...

Dentistry, in the story of its evolution from "tooth tinkering" to modern methods, cites the jeweler's "fiddle-bow" drill as the first of America's mechanical devices for the preparation of cavities.

This and later nineteenth century technical developments—Lewis' hand drill with adjustable head, the finger thimble and hand bur, the first modern dental chair, the advent of sponge or crystal gold for fillings, improvements in the manufacture of porcelain teeth, etc.—were paralleled by developments in the educational field:

In 1826 Leonard Koecker's scholarly *Principles of Dental Surgery* presaged the demise of practicing laymen—a prophecy that ripened with the founding of the first dental college at Baltimore in 1840. Chapin A. Harris' *American Journal of Dental Science*, published in 1849, heralded the coming of other early educational and fraternal magazines, some of which still serve the profession today.

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ASSOCIATED MEDICAL CARE PLANS NEWS

(Continued from Page 1058)

Paul R. Hawley, Chief Executive Officer for Blue Cross and Blue Shield. "It is being proposed to enable the voluntary prepayment Plans to meet effectively the changing trend of public demands for health protection. Failure to do so will invite speedy initiation of a government compulsory health insurance program."

To finance the establishment of a Blue Cross-Blue Shield Health Service, Inc., proposed as an Illinois stock corporation, the Association would be permitted to accept contributions from Blue Cross and Blue Shield Plans. Contributions would be used by the Association to purchase the preferred shares issued by the Health Service corporation, transferring those shares to a voting trust so that contributing Plans would have a proportionate voice in the direction of the Health Service. Common shares in the Health Service would be held solely by the Association.

The necessity for two corporations is largely legal, inasmuch as most Plans would be permitted legally to make contributions to an Association such as that which is proposed, but would not be allowed to invest funds directly in the preferred shares of the Health Service.

The proposals set forth the intent of the Health Service to redeem all preferred shares, on which no dividends would be paid, out of net earnings as soon as possible, with the Association eventually owning all outstanding shares and exercising full control.

The Blue Cross-Blue Shield Health Service would be organized for the purpose of assisting Plans with the enrollment of national accounts, identified as those groups employed by a firm which is not confined to an area served by any one Blue Cross or Blue Shield Plan.

Assistance is specified as (1) soliciting such accounts through the home office of a nationally operated firm in behalf of the Plans, (2) issuing excess coverage certificates for additional benefits, desired by a national account, but which cannot be provided by a local Plan, and (3) providing coverage for employes residing in areas not served by a Blue Cross or Blue Shield Plan.

Both the Association and the Health Service have been designed for the purpose of enabling Blue Cross and Blue Shield Plans to meet satisfactorily the basic demands of national accounts, which are (1) uniform benefits, (2) uniform subscription rates, (3) central agency for enrollment, billing, and collection of subscription payments, and (4) reasonably uniform regulations covering membership and the securing of health services.

Blue Shield Commission Accepts Two More Member Plans

Medical-Surgical Service, Inc., of Clarksburg, West Virginia, was accepted as a full member of Associated Medical Care Plans, and Medical Service Association of Vancouver, British Columbia, as an associate member, at the last meeting of the Blue Shield Commission in Chicago on August 20. AMCP now has a total membership of fifty-three Blue Shield Plans.

An application has been received since August 20 from the Blue Cross Plan in Puerto Rico. The Plan is sponsored by the Medical Association of Puerto Rico, providing medical as well as hospital benefits to 43,459 members, according to the enrollment report for the second quarter of 1948.

Blue Shield Commission Will Present Award to Michigan

A special award will be presented by the Blue Shield Commission to Michigan Medical Service at the Annual Conference of Blue Shield Plans, to be held at French Lick Springs, Indiana, on October 25-28. The award, an appropriately designed plaque, will be made to Michigan for being the first Blue Shield Plan to enroll a million members. Michigan Medical Service reported 1,052,736 members on June 30, 1948.

VOLUNTARY SICKNESS INSURANCE IN INDUSTRY

Voluntary plans for protection against sickness, old-age, premature death and other major hazards now cover hundreds of thousands of workers in the Chicago metropolitan area. This was revealed in a recent study, "Employee Benefit Plans in Chicago," just released by the Research Council for Economic Security, Chicago.

Questionnaires were sent to more than 2,000 employers, both large and small. Of these, 35 per cent were returned, reporting on about 700,000 employes. Of this number, 85 per cent have life insurance and about the same number hospital insurance. These are followed by compensation for wage loss due to illness (69 per cent of employes in reporting firms); pension and retirement plans (68 per cent); surgical benefits (50 per cent); and prepaid medical care (6 per cent). These figures apply only to employes in firms which participated. For the entire labor force, the figures would be somewhat lower. Protection by government systems and by individual employes themselves are not included.

"The purpose of the survey," said Gerhard Hirschfeld, Director of the Council, "is to show as accurately as possible how much protection industry provides for its employes on a voluntary basis. Similar surveys, now under way in St. Louis, Cleveland, Pittsburgh, Minneapolis, St. Paul and other major cities, are expected to throw more light upon the nature and extent of employe benefit plans throughout the country."

The Research Council is a non-profit, non-partisan, privately financed organization engaged in studies in the field of social and economic security. Its chairman is Bertram J. Cahn, President of B. Kuppenheimer & Co.

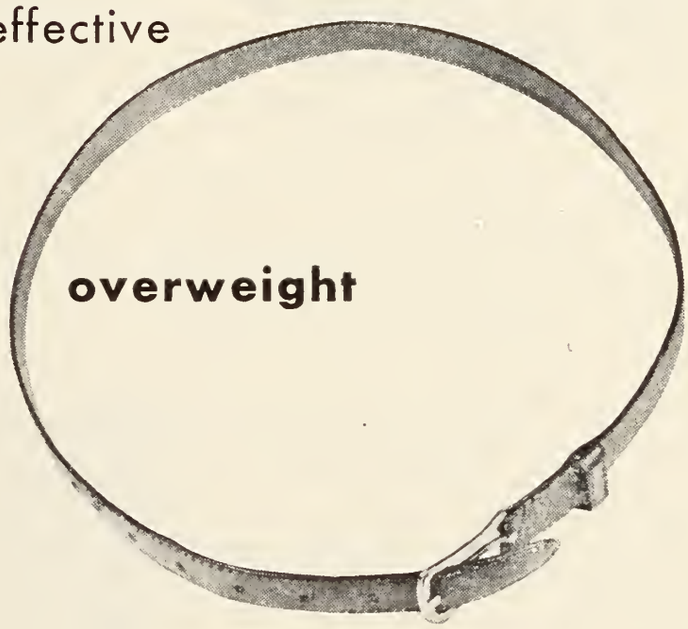
HOSPITAL PER DIEM COSTS

From the first thirty-seven cost questionnaires tabulated at this date, the over-all average hospital per diem cost was $13.01. The highest cost was $19.69, the lowest $7.00. Few of the large hospitals from the metropolitan cities have submitted their questionnaires as yet. The average per diem cost for (10) hospitals reporting in the Southwest District of the Association was $13.65. In the

(Continued on Page 1062)

safe . . . rational . . . effective

in the treatment of **overweight**



Harris, Ivy and Searle conclusively proved that 'Benzedrine' Sulfate, *alone*, safely depresses the overweight patient's appetite—and when caloric intake is sufficiently lowered, weight reduction is facilitated.

After a comprehensive series of functional tests, these same investigators conclude: "No evidence of deleterious effects of the drug (amphetamine sulfate) were observed." (J.A.M.A.134:1468[Aug.23] 1947.)

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Benzedrine Sulfate tablets • elixir

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HOSPITAL PER DIEM COSTS

(Continued from Page 1062)

Northeast District (3) hospitals averaged $14.72. The Southeast District averaged $15.12 for (10) hospitals in which the Detroit area is included. (10) Hospitals in the Northeast District averaged $11.41, while (4) hospitals in the Upper Peninsula averaged $8.91. The per diem costs were taken from Standard Form No. 1 for the period January 1 to June 30, 1948.

Average over-all per diem receipts from City, County, State and Federal Governments were as follows: City—$10.96; County—$9.04; State—$8.80; and Federal—$11.24. The above are weighted averages and include all types of hospitals. The figures presented here will no doubt change considerably as the returns from larger hospitals are received and tabulated.

MEDICAL CARE GROUPS

Our population is divided into four economic groups when considering medical care: These groups are (1) The wealthy—those who are financially able to pay for medical care regardless of how prolonged the illness or how costly the treatment may be; (2) those financially able to care for themselves under all conditions except for prolonged or costly illnesses; (3) those who can meet all normal costs, but who find it difficult to meet the cost of any illness; and (4) the indigent—those who are dependent upon public welfare for all necessities. There is no concern for the first group. Those in the fourth group are normally well cared for in most areas on a local charity basis. Prepayment is designed primarily for and is serving effectively those in the second, and possibly the third group, under the type of legislation as is embodied in S. 545.

No prepayment program whether voluntary or compulsory can guarantee a doctor or a hospital bed for every person.

VALUE OF DOLLAR

The Survey Research Center of the University of Michigan says that the top tenth, in the economic scale, possess 33 per cent of the nation's income. The top tenth, they say, is composed of anybody who blazed through a minimum of $5,700 in 1947. On the other hand, a report of the Marion Harper Associates says your dollar was worth 59½ cents in April, as compared to 64 cents in April a year ago. In January of this year, it hit low ebb of 59.2 cents. So, even if you are in the "top tenth," you only have 59.5 per cent as much as you'd have in normal times.

PHYSICIANS NUMBER 199,755

The Bureau of Medical Economic Research of the American Medical Association estimates that there were 199,755 physicians in the United States as of June 1, 1948.

Frank G. Dickinson, Ph.D., director of the Bureau, says in an article which appears in the August 21 issue of *The Journal of the American Medical Association* that this number is 17 per cent greater than the 170,163 physicians shown in the 1940 AMA Directory. The population of the United States has increased only 12 per cent since 1940, he points out.

ARTHRITIS AND RHEUMATISM

One out of every twenty Americans—more than 7 million persons—is a victim of arthritis or some other form of rheumatism.

Per capita, Congress spent about 9 cents for forest trails, 20 cents for plant and animal diseases and 40 cents for Department of Agriculture research last year, while *from all* sources less than one-tenth of a cent was spent for research in rheumatic diseases.

DISTRIBUTION OF MEDICAL AND HOSPITAL FACILITIES

No other country of comparable size has equalled the medical and hospital systems of the United States. We have more physicians, more hospital beds, more graduate nurses, more laboratory and x-ray technicians, more dentists and better distribution per thousand population than any other country, large or small.

HOSPITAL BEDS WELL DISTRIBUTED

There is always room for improvement, but the following indicates that even now hospital beds are well distributed. About 40 per cent of the counties have no hospitals. Yet, counties are political units and not hospital service areas. Viewing the situation from hospital service areas shows that all but thirteen of these counties are no more than 30 miles from a general hospital. Good roads make this a short distance. Of this thirteen, only five have a population of over five persons per square mile and couldn't possibly support a hospital.

PRINCIPAL ORGANIZATIONS PROMOTING COMPULSORY SICKNESS INSURANCE IN THE UNITED STATES

1. An organization in New York City that operates under four names:
   - (a) The Committee on Research for Medical Economics—Michael M. Davis, Chairman.
   - (b) The Committee for the Nations Health—Channing Frothingham, M.D., Chairman.
   - (c) The Committee of Physicians for the Improvement of Medical Care—Channing Frothingham, M.D., Chairman.
   - (d) The Physicians Forum—Ernest P. Boas, M.D., Chairman.

   Address of the above: 1790 Broadway, New York, N. Y.
2. The CIO.
3. The A F of L.
4. The Communist Party.
5. Individuals in various Governmental agencies, among them the USPHS and the Department of Agriculture.

(Continued on Page 1064)

EXPERIENCE IS THE BEST TEACHER...



Carlos Finlay *(1833-1915)*

proved it in public health

Carlos Finlay, of Cuba, a bacteriologist, believed that yellow fever was transmitted by the stegomyia mosquito. His original experiments did not provide definite proof of his theory. However, he continued his search in co-operation with Walter Reed and the Yellow Fever Commission. The work of the Commission finally proved that infected mosquitoes could transmit the fever. The public health preventive measures derived from these experiments were so successful that the fever in Cuba was under control within a year.

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.



Experience is the best teacher in cigarettes, too!

MILLIONS of smokers who have tried and compared many different brands of cigarettes have found that cool, mild, flavorful Camels suit them best.

Try Camels on your "T-Zone"—T for Taste, T for Throat. See how your taste enjoys the rich, full flavor of Camel's choice. properly aged. and expertly blended tobaccos. See if your throat doesn't welcome Camel's cool. cool mildness.

Yes! Try Camels and see for yourself why, with thousands and thousands of smokers, Camels are the "choice of experience."

• • •

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

(Continued from Page 1062)

CAN THE AVERAGE FAMILY BUDGET AGAINST THE COSTS OF MEDICAL CARE?

The latest reports of the Bureau of Labor Statistics show that its "average family budget" includes four doctors' visits a year for each member of the family, and a serious illness once every four years.

Budget estimates last year ranged from $132 to $222 per family, depending on income. Yet, even with this increase the percentage of family income going for Medical Care dropped from 6.1 to 5.5 per cent.

The Bureau of Labor Statistics concludes that "in any one year the *majority of the families do not require Medical Care costing as much as the budget allowance.*" In other words, if a reasonable amount were set aside each year, even the unexpected medical costs could be met.

People have more ability to pay for Medical Care today than ever before, except perhaps during the war. But are they spending their money for other things?

OBJECTIVE OF PREPAID MEDICAL-SURGICAL AND HOSPITAL CARE

The true objective of voluntary prepayment is to help self-sustaining individuals remove some of the financial obstacles which might stand in the way of obtaining timely care for conditions of an unusual nature.

Most self-sustaining individuals are in a position to meet the expected and normal costs of medical care, i.e., the routine home and office calls. Accidents and illnesses which involve surgery, treatment of fractures and hospitalization are not individually predictable and the voluntary prepayment plans have been devised and developed to assist meeting these unpredictable expenses.

WHAT PART OF EACH DOLLAR SPENT FOR MEDICAL CARE GOES TO PHYSICIANS?

Less than one-third of each dollar spent on medical care is paid to physicians. The physicians' share has declined steadily since 1929.

Year	Total	Physicians Services	Hospital	Drugs, etc.	Dentists	All Other
1929	$1.00	31.7c	13.3c	20c	16c	19c
1935-39	1.00	31.1c	16.9c	20.7c	13c	18.3c
1945	1.00	26.9c	16.1c	23.1c	13.1c	20.8c

INFLATION?

Frederick C. Mills, of the National Bureau of Economic Research, writes that since 1939 the farmer has boosted his prices 272 per cent, but his output has only increased 27 per cent. Manufacturers get 248 per cent more in price for 82 per cent more output. John S. Knight, of the *Detroit Free Press,* says the manufacturers and businessmen want their high profits; the farmers demand, and get, continuing price supports from Congress; the unions clamor for higher and higher wages, and point to corporation earnings as their justification.

"What America must eventually discover is that we cannot continue indefinitely to carry the crushing burden of a projected 28 billion dollar military establishment, maintain one out of every seventy civilians in the United States on the Federal payroll, feed and finance the world, and still maintain a sound economy."

MEDICAL DEGREES

In the last year medical degrees numbered 6,607 compared with 5,490 in 1940, according to the United States Office of Education. Women received 772 degrees in medicine during the 1948 period, an increase of 25 per cent over the biggest number in any previous year. Many of these admissions to medical schools were during World War II because of the manpower shortage.

Army Medicine

SURGEON GENERAL EXTENDS TRAINING PROGRAM LIMIT

The Army Medical Corps has extended until November 1 its time limit for medical school graduates to apply for commissions under the Civilian Resident and the Civilian Intern Training Program.

Widespread interest in the program necessitated the decision by Major General Raymond W. Bliss, Surgeon General of the Army, to extend the time limit from July 1.

Under the program, selected individuals serve out their internships and residencies in civilian hospitals of their choice—interns as first lieutenants of the Medical Corps Reserve and residents as first lieutenants in the Regular Army Medical Corps. Both receive full pay and allowances of their rank, plus $100 a month professional volunteer bonus. Both complete their training just as they would as civilians.

Upon completion of their year's training, interns must apply for Regular commissions and may qualify for residency training. Residents may continue their residency training upon concurrence of the hospital with a view to qualifying for specialty courses leading to certification by American Specialty Boards. Here the Graduate Training Program meets the Career Management Program under which medical officers are assured of continuation in their chosen specialties during Army service unless they choose administrative or staff careers.

Officers who participate in these programs are expected to serve a year of active duty for each year of training they receive.

The Graduate Training program was instituted by General Bliss with the advice and help of the American Medical Association, the Society of Consultants of World War II and other medical organizations, to help bring Army medicine into closer contact with civilian medicine. Superintendents and chiefs of professional services in great civilian teaching hospitals have indicated their wholehearted indorsement of the program. Many of these chiefs now serve also as consultants to the Surgeon General and make regular teaching visits to Army hospitals.

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AMERICAN MEDICAL ASSOCIATION

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CAMINOIDS has a biological value approximately equivalent to that of casein . . . long recognized as a high-quality protein standard. It supplies all of the amino acids recognized as essential to a high level of biological activity. Derived from a selection of rich protein sources: liver, beef muscle, wheat, soya, yeast, casein, and lactalbumin.

Amino Acid Analysis of AMINOIDS, Batch 9000

Amino Acid / Method	As Received %	On Protein Basis N x 6.25=100 %
Arginine	1.26	3.0
Kossel-Block Histidine	1.08	2.6
Kossel-Block Lysine	2.44	5.8
Kossel-Block *Tyrosine	1.74	4.1
Millon-Lugg Tryptophan	0.56	1.3
Millon Lugg Phenylalanine	2.44	5.8
*Kapeller Adler Cystine	0.51	1.2
Folin Methionine	1.03	2.4
Sullivan **-Carthy Threonine	1.51	3.6
Nicolet-Block Leucine	4.33	10.2
Microbiological Isoleucine	3.26	7.7
Microbiological Valine	2.86	6.8
Microbiological		

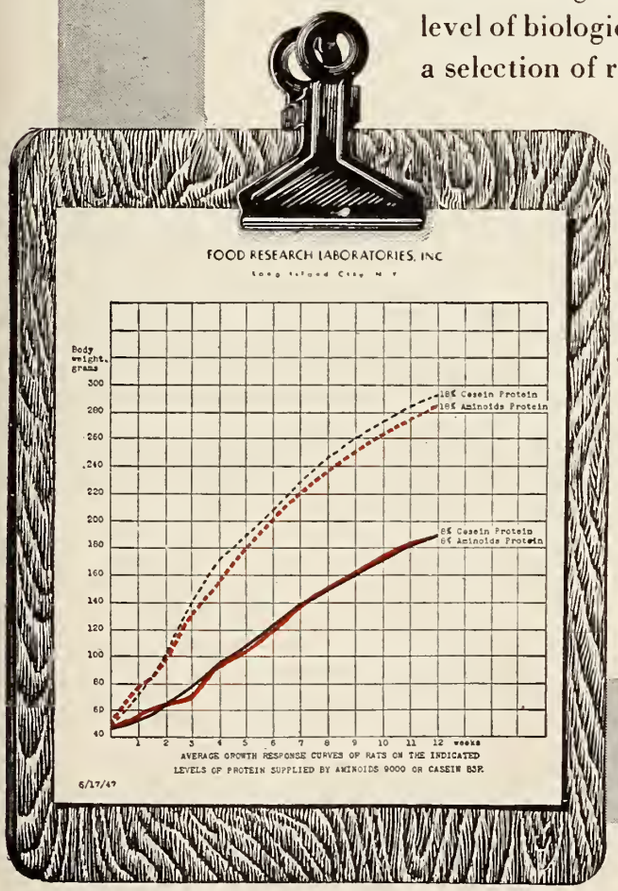
*Tyrosine and cystine are included in the table because of their sparing action on phenylalanine and methionine, respectively.

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Arlington



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Cancer Comment

THE ORAL CAVITY IS NOT IMMUNE TO CANCER

Carcinomas originating in the oral cavity account for three per cent of the total cancer mortality. About six per cent of all malignancies are found in the mouth. These percentages are sufficiently large to warrant attention.

Cancer of the mouth is one of the most easily discoverable forms of cancer. Many of the causes are well known, and the tissues are accessible for observation and treatment. The problem develops into one of looking for oral abnormalities. Physicians should routinely and carefully examine the mouth of every patient as part of the general examination. If this is not done, an important part of the examination is neglected, for recognition and proper treatment in early stages will accomplish nearly 100 per cent cures.

Too frequently the dentist confines his interest to the teeth, neglecting the mucosa of the mouth. He should not neglect the opportunity presented by the semiannual cleaning and inspection of the teeth, a practice encouraged by dentists and followed by many people, to carefully examine the cheeks, tongue and gingival tissues for suspicious sores, swellings or other evidence of pathology. Laryngologists consider that their special field begins posterior to the anterior pillar of the fauces, so that those oral tissues frequently the seat of cancer are neglected by both dentists and physicians.

In the days before the era of intensive specialization, the physician's first approach to every patient was an examination of the tongue and mucosa of the oral cavity. He recognized instinctively that the mouth was a barometer of health or sickness. Appearance of the oral tissues was a definite aid to diagnosis. The physician was interested chiefly in a coated, dry, or moist tongue, hyperemia or ischemia of the buccal mucosa, the blue line of lead poisoning along the gum margins, or the cyanosis associated with cardiac diseases. Unfortunately in those times as well as today, many oral malignancies were in an advanced stage when first recognized.

It is not generally recognized that, per square inch of surface involved, the mouth contains a greater variety of lesions than any other region of the body, and cancer is among the most important of these. The accessibility of the oral cavity for examination eliminates any reason for an oral lesion going unnoticed.

The most important oral pathologic manifestations are: leukoplakia, Vincent's infection, warts, papillomas, tubercular, syphilitic and cancerous ulcers, submucous nodules, cysts and adenomas, stomatitis, glossitis, fissured tongue and bulging teeth. Pyorrhea and the streptococcus infections with their inflamed mucosa are also common lesions of the oral cavity.

The danger from irritations caused by illfitting artificial dentures should be stressed to the users of these appliances and they should be impressed with the necessity of adjustment or replacement where their continued use causes discomfort. Irritations to cheek or tongue caused by carious or broken teeth should be eliminated by repair or extraction of the offending tooth.

When leukoplakia of lip, cheek or tongue does not respond to vitamin or antisyphilitic therapy it should be considered a precancerous lesion and treated accordingly.

While cancer in general is mainly a problem for the physician, cancer of the mouth in its earliest stages is of interest to the dentist. In many ways, cancer of the mouth should be to the dental profession what cancer of the uterus, breast and skin are to the medical profession in that the great majority of malignant lesions in these sites can be recognized in early stages if and when they are looked for.

Had the same amount of study been devoted to the etiology of cancer of the mouth as has been given to cancer in other parts of the body, possibly our knowledge of the disease would be farther advanced than it is now.

Malignancies of the mouth should never develop beyond the earliest stages, and when dentists and physicians alike give as careful attention to suspicious oral lesions as they do to similar lesions elsewhere in the body, the mortality from this type of cancer should be markedly reduced.

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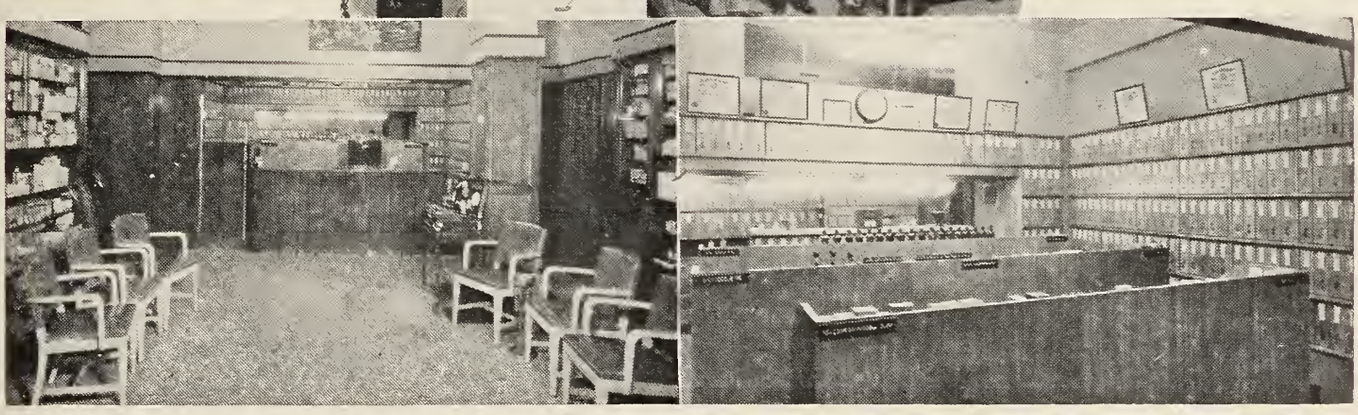




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PR in Practice

PR Committee Prepares Budget and Program

The MSMS Public Relations Committee sweated out a budget and plan for 1949 on a hot August day in Owosso. The combined thinking of twenty tried and (by the time they finished) tired men evolved the PR program for the ensuing year.

L. W. Hull, M.D., Chairman of the PR Committee, called the meeting to order at 12:45 and kept hammering at a ten-item agenda that developed the report of PR progress, the Committee on Cinema's production of "Lucky Junior" (first MSMS PR film), MSMS activity at the Michigan Rural Health Conference, a review of the Woman's Auxiliary activity planned for 1949, consideration of PR "impractices", preliminary plans for PR 1949 model, and detailed budget to carry it on.

The plan developed a balanced program using radio, cinema, newspapers, publications, schools, display, organizational activity, public speaking and personal doctor-friend activity to put across a dynamic attack on the challenge to medicine of those who do not (or profess not to) believe that the American way of practicing medicine and protecting health can best meet the needs of the people.

Michigan is fortunate that it stands as a bulwark against socialized medicine on the national scene, for it is repeatedly referred to as a state which has shown by its outstanding health activities and its voluntary medical and hospital service plans that the medical profession is united in a program that leaves no stone unturned to serve the people better.

Michigan Rural Health Conference

The Michigan Rural Health Conference was well publicized. Nearly a million lines of type were set in Michigan newspapers, twenty radio stations carried announcements of the Conference, and it was publicized over sixty stations in conjunction with the "Tell Me Doctor" program both in and out of Michigan.

"Tell Me Doctor"

The "Tell Me Doctor" program is now being heard daily over twenty-three Michigan stations. In addition it is being carried over twenty stations in Oklahoma, twelve in Virginia, several in South Carolina, and one in West Virginia making a total of sixty or more stations over which this program is now being broadcast throughout the nation.

Two Bills

Two Bills with very similar last names visited the MSMS Public Relations Office during the course of the past month. One was Bill Dozier of the Alabama State Medical Society and the other Bill Doscher of the AMA. Both came to observe a state medical society's model PR setup.

Sex Education

The thirteen sex education scripts have been completed as well as the teacher's guides to accompany them. Titles of the scripts, which will be recorded shortly by Wayne University for use in the public schools, are:

1. Introduction to Series
2. Physiology of Sex
3. The Female
4. The Male
5. Fertilization and Reproduction
6. Menstruation
7. Masturbation and Nocturnal Emissions
8. Sexual Behavior
9. Childbirth and Abortion
10. Venereal Disease
11. Necking, Petting, and General Dating
12. Drinking and Delinquency
13. Home Environment and Happy Marriage

Woman's Auxiliary Brochure

A suggested program for "Health Month in Michigan" and aims and projects for the Woman's Auxiliary for 1949 has been completed and published. Distribution of this brochure is being made at the present time.

"Lucky Junior" Making His Rounds

"Lucky Junior," the MSMS moving picture, is now making the rounds of motion picture theaters in the state. Twenty-five prints of the film have been made and are being scheduled and shown. Four hundred theaters, with a total attendance during the showing of the picture of nearly a million persons, are expected to present this dramatic production which illustrates the contrast between the child of today and the child of one generation ago in respect to his opportunities for living a long and healthy life—thanks to immunization and to the modern disease control programs developed by the medical profession.

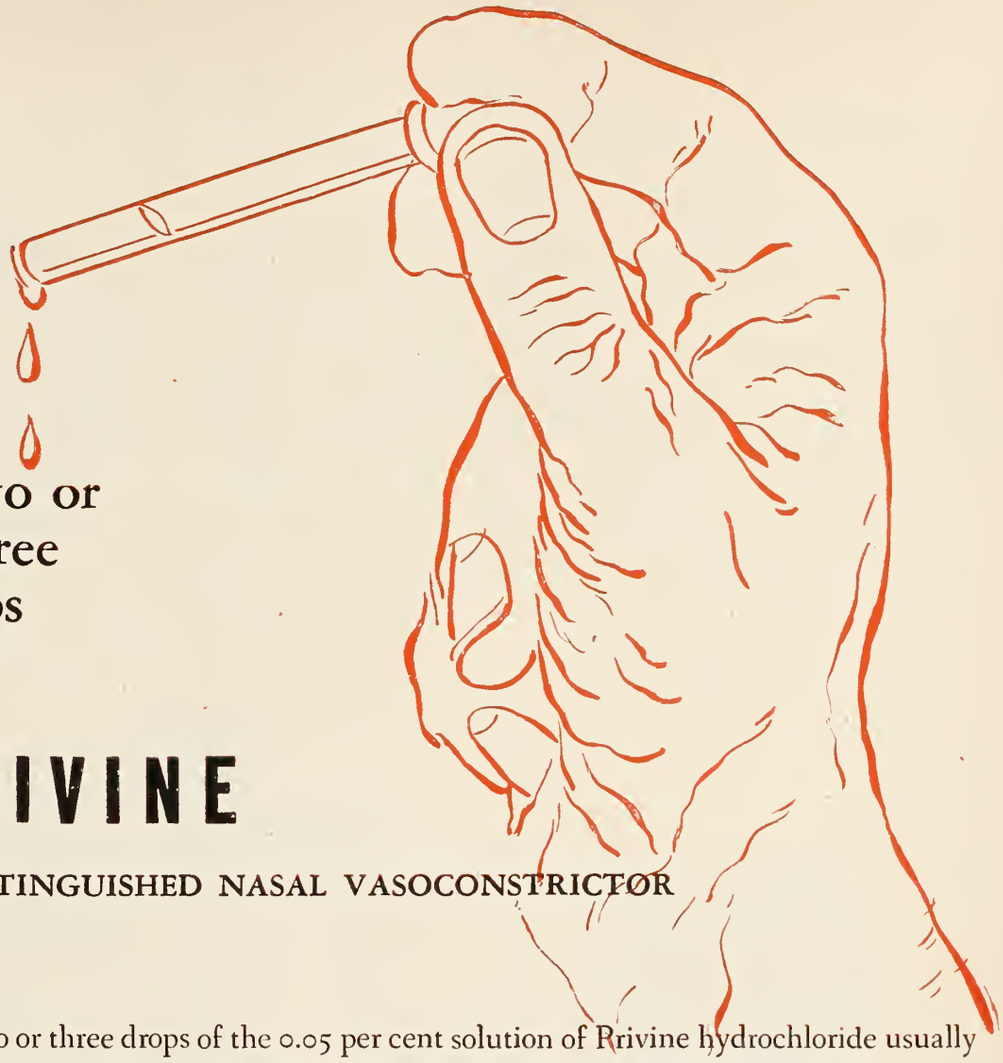
Medical Associates Brochure Being Distributed

The long awaited Medical Associates Brochure has been completed, presented to the House of Delegates and to The Council, and is now being distributed to the Schools, the Woman's Auxiliaries of the State and County Medical Societies, and other interested organizations and persons.

The brochure answers a pressing need in the health field for a single volume of factual material attractively presented. It presents the opportunities which these fields, so closely allied to the practice of medicine, offer to students who do not wish to go the long and difficult route to an M.D. degree, but who sincerely wish to serve the health needs of the people as aides to the doctor of medicine and the dentist in affecting a wider distribution of medical and dental care. For a copy, write MSMS Commission on Health Care, 2020 Olds Tower, Lansing 8.

Annual Session

Again the MSMS Annual Session attracted wide notice throughout the State. The development of newspaper and radio publicity in Detroit was augmented by a state-wide series of releases to Michigan home town newspapers and also to newspapers in the home towns of the guest essayists who addressed the General Assemblies.



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Political Medicine

MEDICAL INSURANCE

A knock-down, drag-out battle is in prospect over the compulsory health insurance plan which has received the endorsement of the Truman Administration. Undoubtedly the proposal will play a part in the coming political campaign. Senator Taft has challenged the Democrats to make an issue of the program, and endorsement of the plan at this time by the President indicates he has accepted the challenge.

Such a program of compulsory Federal health insurance and medical aid is extremely controversial.

Most doctors, probably, will be opposed. Some medicos favor a system of compulsory insurance, however, and some helped in preparing the plan.

Critics oppose it on the grounds that it is "socialized medicine;" that it would give the Federal Government control over physicians; that it means the destruction of initiative on the part of doctors and a lowering of medical standards and the quality of medical care. They charge that a tremendous medical bureaucracy would be built up as a result of the adoption of such a plan with an attendant increase in cost, red tape and inefficiency.

Proponents of the plan point out that our present system of medical care is inadequate to protect the health of the American people; that many areas of the country are without medical protection; that voluntary health insurance programs are beyond the means of people in low-income groups; that, under the plan proposed, the charge of socialized medicine would not apply because the patient would be free to choose his doctor and the doctor, in turn, would be free to join or refuse to take part in the Federal plan.

These are only a few of the arguments pro and con. There are many others.

We admit frankly we don't know the answer—yet. We hope to arrive at a decision after all the facts have been considered. We do not like the idea of adding further to our already top-heavy Federal bureaucracy. Neither do we like the idea of people being denied medical help for economic reasons.

There will be ample opportunity to study all sides of the question in the coming months. It will be constantly before the public eye. It is suggested that it is every citizen's duty to study the matter thoroughly. Dispassionate consideration is not advanced by projecting this question as we enter a national political campaign.—Editorial, *The Flint Journal,* Sept. 4, 1948.

SHARE-THE-HEALTH PROGRAM URGED BY PRESIDENT TRUMAN

President Truman urged the nation to adopt a share-the-health program based on compulsory insurance and vast outlays to expand medical services.

"Millions of our citizens cannot afford good medical care," Mr. Truman said in stamping his approval on a 10-year plan designed "to bring good health within the reach of everyone in this country."

Called "Campaign Document"

That plan, drafted by Federal Security Administrator Oscar R. Ewing at the President's request, embraces major points of similar administration proposals which the 80th congress rejected.

Inability to pay for medical care is killing 325,000 Americans every year, a public health report said in recommending a 10-year multibillion-dollar health program.

Federal Security Administrator Oscar R. Ewing, after seven months of research, outlined in a 183-page report to President Truman the state of the Nation's health and recommendations for improving it.

His proposals not only are aimed at saving the 325,000 lives lost annually, but also to help save 4,300,000 man-years of work and $27,000,000,000 in National wealth he says are lost annually through sickness.

Critics have called such plans "socialized medicine."

The program is almost certain to become a major issue in the presidential campaign. It has been approved by the Truman Administration and most labor organizations.

It has been opposed by most medical men and the Republican Congress has refused to pass legislation providing for it.

Its release yesterday by the White House prompted Rep. Frances P. Bolton (R., Ohio) to label it a "campaign year document."

The Ohio congresswoman, who has taken an active role in health legislation, told a reporter:

"Beautiful Dream"

"It's a beautiful dream and a very challenging thing. But the solution of these problems will not be aided by a political campaign."

"It's most unfortunate to make it a political football," she added.

John M. Pratt, administrator of the National Physicians committee, said in Chicago last night that the Ewing program would be a "political distribution of health care in the United States." He estimated the cost at "upwards of $6,000,000,000 annually."

The detailed program reported to Mr. Truman was made at his direction after Congress cold-shouldered a similar proposal last January.

More than 800 doctors aided in its preparation after a meeting of medical and lay delegates in Washington last May.

In a statement issued Thursday, Mr. Truman again called on Congress to enact the public health program and indorsed the Ewing report.

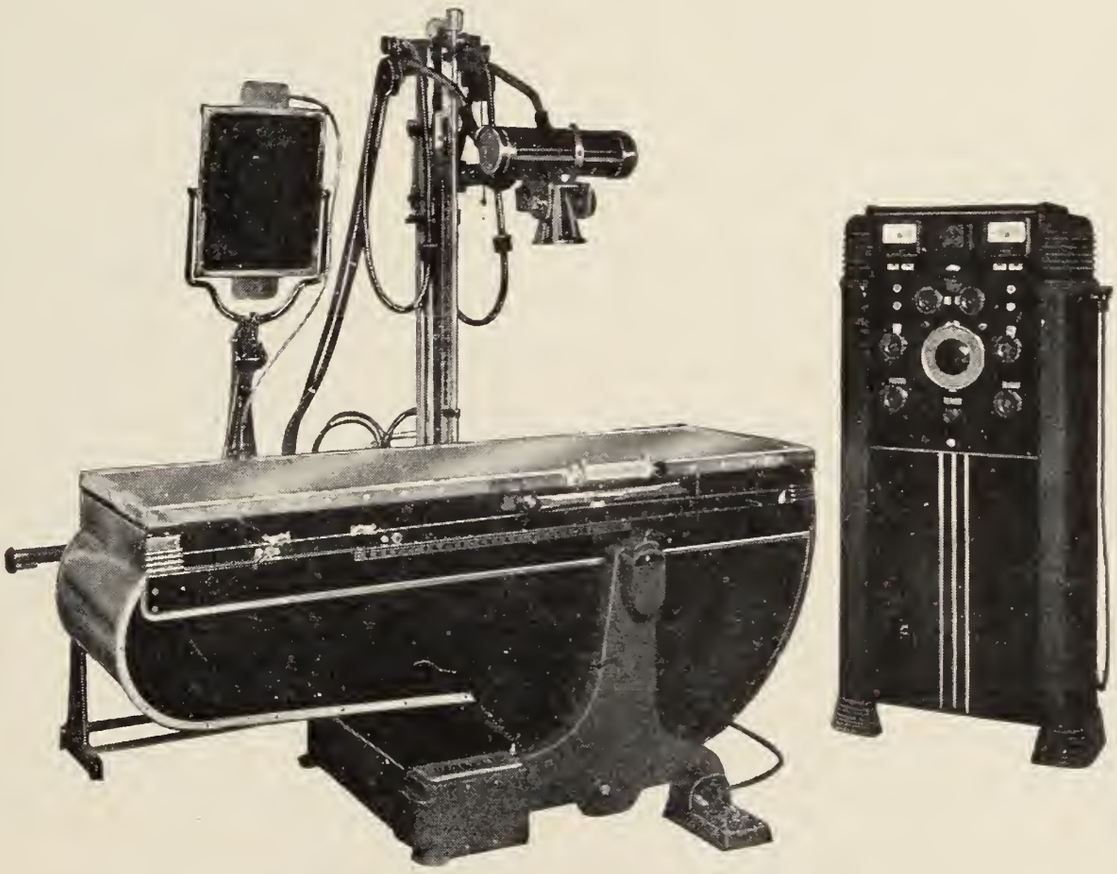
The Federal health insurance by Ewing proposes to help "millions . . . meet the costs of health services" because "voluntary insurance plans cannot do the job that has to be done."

The insurance would cover the cost of doctor's fees,

(Continued on Page 1072)

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SHARE-THE-HEALTH PROGRAM

(Continued from Page 1070)

hospital care, medicines and appliances. Dental care and home nursing would be provided later, possibly at extra cost.

Patients would have the right to choose their own doctors. And the doctors, in turn, would be free to join or refuse to take part in the Federal plan.

Their fees would be paid from the Government fund to doctors, dentists, nurses and hospitals "at a rate mutually agreeable to them and the insurance system."

A special tax is recommended to pay for the program. It would be imposed on wages and salaries, starting with one-half to one per cent of the first $4,800 income.

State and local officials would be in full charge of actual operation.

Ewing, insisting that his plan is not socialized medicine, recommended:

1. Doubling hospital facilities by 1960 at a cost of $9,000,000,000. He said at present there are only half enough hospital beds in the United States.
2. Federal aid to help medical colleges train 227,000 physicians by 1960.
3. Increasing the number of dentists from 75,000 now to 95,000 by 1960.
4. Spending up to $100,000,000 a year by 1960 in Federal money for medical and related research by civilians.
5. Boosting facilities to care for children, the handicapped, the aged and mentally sick.
6. Ending discrimination against Negro physicians and patients.

Ewing said the plan is a "thoroughly American system" and rests upon insurance principles "which have been part of our national fabric for generations."

Denies Political Aim

Ewing, however, said in his report to Mr. Truman "it is pure poppycock and deliberately misleading to say that government health insurance would make medicine a 'political football.' "

He said each year 325,000 Americans die who could be saved if present medical knowledge and skills were fully available to them. He estimated that 4,300,000 man-years of work and $27,000,000,000 in national wealth are lost annually through sickness and disability.

The nation now spends about $8,500,000,000 yearly for health and medical services, he said. Most of this comes from private sources, with federal, state and local governments putting up $1,962,000,000.

Would Increase Outlays

To carry out his 10-year plan, Ewing proposed increasing federal outlays from $743,000,000 to $2,312,000,000 by 1960 and boosting state and local contributions from $1,219,000,000 to $1,795,000,000.

The FSA chief said the proposed health insurance program might start with coverage offered only to those workers now qualified for social security. Its ultimate aim would be to include all citizens.

It would be financed at the outset by a tax of from one-half to one per cent of the first $4,800 earned. Later, the levy might range up to four per cent as the medical care services were expanded, with employer and employe dividing the cost of the premium fee.

Says Plan Approved

Mr. Truman noted in his statement that Ewing's federal aid proposals were approved by some 800 medical and civic leaders at the National Health Assembly here last May.

The assembly, however, did not endorse the compulsory insurance plan, although he said it did support "the principle of contributory insurance as the basic method of financing medical care for the large majority of our people." Mr. Truman added:

"I believe that federal legislation in accordance with this program would carry us far toward the objectives stated in this report. However . . . state and local governments, medical schools of all types, hospitals, members of the medical professions and other interested groups and citizens will all have to work together if we are to reach our objectives."—Associated Press Release.

BRITAIN TO ROUND UP HEALTH PLAN SLACKERS

LONDON, Sept. 8—The Labor government is planning a roundup of more than 1,000,000 men and women who have failed to register under the new health service act. It is estimated they owe the state more than $8,000,000 as arrears on their contributions. Most of those who haven't registered are either unemployed or self-employed. When authorities catch the defaulters they will have to pay their arrears in full and will be liable to fines up to $360 for their unpaid dues and further fines of $40 for every week they stay out of the scheme.—*Chicago Tribune,* Press Service. Submitted by A. L. Miller, Publisher *Battle Creek News,* with the note: "Maybe they'll have to be chloroformed."

HEALTH-PLAN TALK COMING TO BOIL

You're going to be hearing about Federalized health insurance and hospitalization during the Presidential and Congressional election campaigns. It will come to a boil in the new Congress after January.

There'll be speeches about it by Truman and Dewey. Also by Dewey's running mate, Gov. Earl Warren. He's favored government insurance legislation in California.

The National Physicians' Committee is at work on its voluntary proposal to counteract what it calls "socialized medicine." The Senate's Labor Committee is under orders to turn in a report, voluntary versus compulsory, by next March 15. If the Democrats should win control of the Senate that report is more likely to back up Truman's compulsory proposal than Senator Taft's voluntary bill.

Federal Security Administrator Oscar Ewing's recent bulky recommendation for a 10-year Federal-State program with big increases in Federal appropriations, is

(Continued on Page 1074)

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HEALTH-PLAN TALK COMING TO BOIL

(Continued from Page 1072)

being used as a textbook by Democratic congressional candidates in industrial districts.

The Ewing report says voluntary plans can't do the job. One of its most interesting suggestions is collection of Federal taxes on the basis of worker ability to pay. That is yet to be explained. Some compulsory bills would collect as much as 3 per cent from worker and 3 per cent from employer in payroll taxes, on wages under $3,000. That would be in addition to social security taxes, now 1 per cent against each.—*Detroit Free Press,* Washington Bureau.

SOCIALIZED MEDICINE AS A POLITICAL ISSUE

In the news broadcast Friday morning, September 17, 1948, Alex Dryer mentioned socialized medicine extensively. He says it has been projected into this present campaign but should not be there, as it is not an issue. The President and Mr. Oscar Ewing, his political manager and Director of the Federal Security Administration, have injected the subject again recently with the release of reports and publication of figures of deaths caused for inability to get medical attention, and of tremendous industrial losses because of man-days of labor loss.

Mr. Ewing and Mr. Truman both specifically deny that their program is socialized medicine, but their political opponents claim that it is very definitely socialized medicine. The medical profession has so interpreted it. Mr. Dryer says it cannot be acted upon immediately because neither party is unified in its belief on the subject. Some of the Democrats are opposed, and the Vice Presidential candidate of the Republican Party is in favor of it. He reported that the insurance tenets of the plan are opposed quite generally by the medical profession, but that some groups of the profession are in favor of it. Many of them are in favor of the social security program of which socialized medicine is a part. He suggested that possibly the thought of the medical profession might change as it did in England if assurance can be given that the profession will be free from Bureaucratic dictation.

That was the gist of the news broadcast. Those of us who have the privilege of reading the British Medical Journal know that the situation in England is not a happy one. The Bureaucrats have not lived up to the promises they made when the second plebiscite was taken. It was publicized in Britain as it has been in America that the doctors could enter this voluntarily or could stay out as they choose. Over a million people in Great Britain have chosen to stay out, and now the Government is after them compelling them to join up and pay their assessment rates and fining them for failure to do so, as indicated by a news item September 9, 1948, from London. If everybody in Great Britain is compelled to join the socialized medicine program, the doctors will of necessity have to co-operate to earn a living. The same thing will hold in America.

While Mr. Dryer believes the issue is not properly in this campaign, the medical profession can see nothing else but that the issue must be met now. If we supinely accept what is dished out to us from Washington, we can only blame ourselves for the condition that will ensue. Mr. Dryer mentioned that about 36,000,000 people now have Blue Cross and Blue Shield, but that it cannot cover the very group of people who need the most protection. Neither is that group covered by the plans from Mr. Ewing and the Bureaucrats. That group would be covered under the Taft Bill which is being considered by the Senate Committee on Labor and Public Health.

COMMENTS FROM MARJORIE SHEARON, PH.D., LEGISLATIVE CONSULTANT

"To begin with, it is ludicrous for an out-and-out politician like Ewing to publish a report on the Nation's health. Such a report should emanate from the Surgeon General of the USPHS. This is exactly the sort of thing that former Commissioner of Education Studebaker complained of when he resigned. Here is a document politically conceived, politically engineered, and politically timed. Can one doubt it is intended to help put Ewing on the map and to publicize the President's legislative program? Ewing has endeavored to make himself and his top administrative assistants spokesmen in the highly technical fields of health and medicine. Does a report on health require tinkering by professionally unqualified persons?

"Snuggled away innocently enough in Ewing's plans are some truly fantastic proposals. There is one calling for 2,800 health educators—one for every 50,000 persons in the country. Perhaps you would say "highly desirable." But do you know what a health educator does? Theoretically such an educator helps people to acquire knowledge concerning health and its attainment.

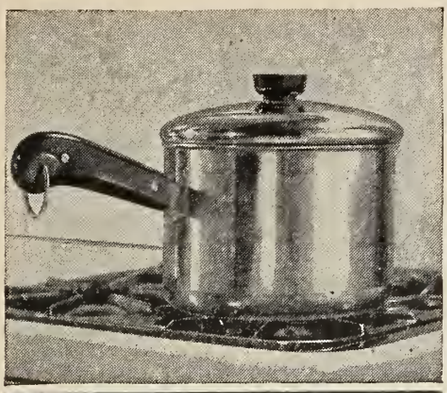
"Actually, under the training program of the Public Health Service, such educators receive an unfortunate indoctrination in the philosophy of State medicine. Perhaps they are sent to Ann Arbor to be indoctrinated by Nathan Sinai. Or they may go to the University of North Carolina to hear Dr. Lucy Morgan, daughter of TVA Morgan, expatiate on the wonders of Social Security medicine. Or they may go to Yale. In any event, training, wholly or partly at public expense, includes a liberal education in the advantages of public medical care. Persons so trained are then supposed to spread the gospel in every community where they are sent."

* * *

"Taxes amounting to 3, 4, 5 or maybe 6 per cent of payroll would be collected from hapless workers and employers compulsorily. The money would be put into the Federal health kitty. Whenever the Secretary of the Treasury wished to spend the funds for other purposes, he could print IOUs, put them in the kitty, and siphon off the "trust" fund. *$10 billion a year is such a temptation to bureaucrats and politicians! The health kitty would consist of possibly 3 per cent in social security taxes and an equal amount in increased income taxes.*

"It is astonishing that Ewing has the effrontry to publish such a report as 'The Nation's Health.' He has

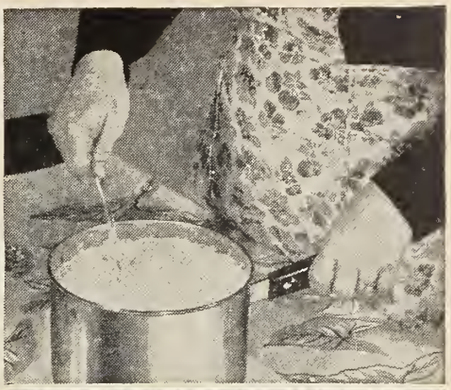
(Continued on Page 1078)



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2. Float measured powder on top of the water



3. Mix with a large spoon or fork

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Editorial Opinion

RED PILLS

Sixty days before election President Truman tossed socialized medicine into the campaign.

The approach, this time, was through a report by the Federal Security Administrator, which proposed to "save" upwards of 300,000 lives a year by an expenditure of Federal funds reaching $2,312,000,000 in 1960.

The President praised the report, which urged Congress "to enact, as President Truman has recommended, a system of Government prepayment health insurance."

Which gets right back to the old Wagner-Murray-Dingell bill for introducing political medicine into the United States.

The Federal Security Administrator who prepared this campaign document is Oscar R. Ewing, appointed vice chairman of the Democratic National Committee in 1942, who is now actively stumping for Truman's election in November.

This would indicate how nonpolitical and scientifically detached the gentleman is.

The American medical profession is overwhelmingly opposed to the adoption of "Red medicine" in this country.

A majority of the American people as shown by opinion polls is opposed to it.

The Socialist Government of Great Britain forced it upon the people as part of a "womb to tomb" coverage against the vicissitudes of life. The cost is a heavy burden on the already over-strained British economy.

A few days ago it was reported that a million persons in the United Kingdom hadn't bothered to register for its "benefits."

The experience of New Zealand was that government health insurance turned into a racket in which doctors and patients conspired to defraud the taxpayers.

Yet a powerful official lobby has been created in this Country to sell socialized medicine, as well as other aspects of the socialist program, to the American people.

The core of this lobby has been the Social Security Board.

A subcommittee on publicity and propaganda of the House Committee on Expenditures in the Executive Departments has discovered that "extraordinary executive pressure" was exerted upon the staff of the United States Public Health Service to further the campaign for socialized medicine."

The SSB has been spending about $2,000,000 a year in "public relations activities"—a euphemism for propaganda.

Chairman Harness of the subcommittee thinks it reasonable to ask "why these agencies should be permitted to spend public money to generate an entirely artificial public demand for socialized medicine in the United States.

The answer is simple. They were authorized and encouraged to do so by the New Deal fellow-travelers, who had allowed themselves to be hypnotized into believing that the American way of life was outmoded and should be replaced by socialistic totalitarianism.

The American people are better served today by private medicine than are any other comparable people by any form of medicine.

Areas still exist in this Country, as a result of its uneven distribution of wealth and population, where doctors and hospitals are inadequate to the needs.

The costs of medical care and hospitalization strain middle incomes. The rich can afford them. The poor are treated free.

The real sufferers are the private patients living on moderate wages and salaries, who are compelled to pay not only for the hospital treatment they received but also for grandiose social service setups, and other frills, which do not concern them.

A measure of relief is already afforded by private group insurance and by beneficial funds created by unions and industries.

The need for even better health facilities is now widely recognized by the medical profession and laymen.

The only possible benefit from the synthetic campaign to sell medical Socialism to this Country is that it will force the professional—in self defense—to exert itself still further to extend and improve its service to the public.

Only in that way can it remove the danger that some day the reds and the pinks will take its job away and hand it over to the politicians and bureaucrats.

The problems Truman proposes to solve the Moscow way can be far better solved the American Way.—Editorial in *Detroit Free Press*, September 13, 1948.

WHERE ARE THEY NOW?

A problem seems to be involved in the acquisition of medical talent for the Army whose forces are on the point of being expanded by the first peacetime draft in the history of this Nation. The 80th Congress excluded a section from the Draft Act which would have required the registration of doctors through the age of 45; for this section would have singled out one portion of the male population over the age of 25 in a discriminatory way.

There seems to be widespread reluctance among the men who were certified as available by the late procurement and assignment service to realign themselves with the medical-military machine in these days of avowed peace. A good many reasons have been advanced to explain this reluctance, but these seem to follow three general patterns.

The first was the utterly capricious waste of medical talent by the Army. From some archaic logistic problem it was decided that there must be 6.5 medical officers to service one thousand troops regardless of the state

(Continued on Page 1078)



The sooner the treatment of adrenal cortical insufficiency is initiated, the shorter may be the period of convalescence and the milder the patient's disabilities.

And the closer the therapy comes to replacing the multiple action of the whole cortical hormone, the more effective it can be.

Therein lies the therapeutic excellence of ADRENAL CORTEX EXTRACT (UPJOHN)—it is a specially extracted preparation from the whole gland containing the multiple active principles of the cortex. Whenever such typical symptoms of cortical insufficiency as lassitude, lowered muscular tone, markedly reduced resistance to infections, loss of weight, depression and mental apathy call for hormone replacement, ADRENAL CORTEX EXTRACT (UPJOHN) conveys in fullest possible measure the requisite cortical principles.

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WHERE ARE THEY NOW?

(Continued from Page 1076)

of training or the locale of activity of those troops. This ratio produced a vast immobilization of medical talent at the fixed installations within this continental limit and in bivouac or with inactive units over the face of the globe. The Navy seems to have made out very well in its global activity with a ratio of 3.2 per thousand but there is no evidence that this information has altered the reasoning of the Army in any degree.

A second complaint was the general subordination of the Medical Department to the parallel line or other service sections. The Surgeon General had no voice directly with the Joint Chiefs of Staff. In lower echelons the doctor was just "Bub" to the line officer of equal grade. A series of phenomena stemmed from this: one of the more ludicrous was the assignment of the medical officer to tasks which were in no way related to his professional training and which thus were wasteful of medical manpower in a corollary sense. In the Mediterranean Theatre, for instance, General Arthur Wilson caused medical and dental officers to be assigned for tours of duty as military police in the fleshpots of Naples—while hospital and aid station personnel were struggling with the steady flow of casualties from Cassino and the stalemate at the Anzio beach-head.

A third complaint can best be illustrated by the suggestion which has appeared spontaneously in thousands of locales: since war and the risk of war which were present in 1942 have disappeared in this year 1948, perhaps a second look at the deferred lists of 1942 might reveal enough men with such slight defects in peacetime and such minor dependency problems in peacetime that the medical needs of this peacetime Army might well be supplied with highly competent medical talent without calling again on those who volunteered a little while ago. —William Bromme, Editor, *Detroit Medical News.*

TRENDS IN MEDICAL CARE

Some of the trends noted today are:

1. Growth of voluntary prepayment plans.
2. Planned distribution of medical and hospital facilities.
3. Development of medical practice in groups.
4. Growth of tax-supported plans for medical care of medically indigent and indigent.

MEASURING WORM

The Public Health Service, now of the Federal Security Agency, issued a bulletin, "Fact Sheet for the 1948 National Negro Health Week," which was observed April 4-April 11, 1948. The theme this year was "A Practical Health Program for Myself and My Family. Learn what we ought to know—Health Education. Do what we ought to do—Healthful Living." That is an exact quote—we do not attempt to interpret. But the next sentence is the inching of the measuring worm, just a little encroachment into socialized medicine at each opportunity, and these opportunities are found too frequently:

"In the participating communities, the individual Negro will be urged to clean his home and premises, check his health habits, seek proper medical aid and obtain corrective treatment when needed. *His child will receive a physical check-up at school* and will be taught fundamentals of good health through participation in health plays and contests. Civic groups and health departments will stage clean-up campaigns, *arrange for group x-rays and blood tests.*"

This is a well formulated program, established by Booker T. Washington, and has done much good work. We could not help noticing that now that the Federal Security Agency is at the helm it cannot forego the opportunity to advance socialized medicine.

COMMENTS FROM MARJORIE SHEARON

(Continued from Page 1074)

paid no attention to testimony at hearings before the Senate Health Subcommittee. He has used absurd statistics. Proceeding on the premise that every worker absent from his job because of sickness or disability would have added over $15 a day to the national product had he worked, he arrives at the utterly fantastic figure of $27 billion a year as the national loss due to sickness and disability. Yet when he discusses the ability of individauls and families to pay for their medical care, he would have us believe that over half the population is so poor it cannot afford to purchase voluntary health insurance or meet the costs of a major operation or of a chronic illness. *According to Ewing, when workers lose wages because of illness, it is high wages. When those same workers come to pay their doctor's bills, they are all poverty-stricken, low-income people. How remarkable!"*

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Twenty-five Years of Precipitation Studies in Syphilis

1923-1948

By Reuben L. Kahn, M.S., Sc.D.
Ann Arbor, Michigan

THE EDITOR of this Journal, Dr. Wilfrid Haughey, kindly asked me to write a special article on my work. "As this is the twenty-fifth anniversary of your test," he wrote, "it would be very fitting to take some special notice of it." The fact is, I consider it a privilege and pleasure to address my colleagues and numerous friends of the Michigan State Medical Society.

It was the early fall of 1919. I had just been discharged from the Army of World War I, and the late Dr. William H. Park, under whom I received my doctor's degree in bacteriology at New York University Medical School, invited me to become a volunteer instructor in his department in order to keep in close touch with openings in my field. Soon two positions came to my attention. One was to work with the late Dr. Carroll G. Bull, professor of immunology of the School of Hygiene and Public Health at Johns Hopkins University; the other was to reorganize and assume charge of the Serology Laboratory of the Michigan Board of Health. The latter position offered full freedom to carry on my own research investigations in my spare time, and early January, 1920, found me on the way to Lansing.

In those days, no practical precipitation test for syphilis existed. Various Wassermann techniques, based on complement fixation, were in common use. A number of precipitation techniques had been published, such as the Sachs-George and Meinicke tests in Germany and the Dryer and Ward test in England. It happened that one of the technical assistants in my laboratory, Mr. Jacob Landau of Vienna, was fully familiar with the first two tests, and I was familiar with the third. After giving these tests a trial, they were found to be considerably undersensitive compared with the Wassermann test employed in the laboratories of the Michigan Department of Health. Their use was thereupon abandoned.

An explanation, common in those days, for the failure to develop a practical precipitation test for syphilis was that the complement fixation technique was inherently more sensitive than the precipitation technique; hence, it was believed that a precipitation test could never achieve the high degree of sensitivity of a complement fixation technique. But this explanation did not seem reasonable to me since, as is well known, the precipitation technique in immunity is extremely sensitive in the detection of minute amounts of antibody.

The thought had been persisting in my mind that the reason why different workers had failed to develop a practical precipitation test for syphilis might be due to the nature of the precipitation phenomenon with lipid antigen; that, because of this type of an antigen, this phenomenon is unique and is governed by special colloid chemical factors. This thought led me in my spare time to carry on some experiments which would throw light on the mechanism of precipitation with syphilitic serum and lipid antigen.

It is not customary to mention failures when describing the development of some scientific work. But failures were the rule until the fall

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of 1921, when I began to see signs of success. Actually, I began to observe relatively rapid precipitation in especially prepared mixtures of serum and lipid antigen. This encouraging finding served as a stimulus to continuous experimental trials. It seemed that at least some factors governing precipitation in syphilis were bound to come to light by these experiments.

Up to that time I had given no thought to the development of a practical precipitation test for syphilis. My aim was to gain some understanding of the phenomenon of precipitation in syphilis. However, on Thanksgiving eve of 1921, I walked home from the laboratory at a faster pace than usual. I wanted to tell my wife the exciting news. I had succeeded in bringing about spontaneous precipitation on mixing some strongly positive serums with a specially prepared antigen suspension. This observation meant that I was on the right track, that my experiments must be approaching conditions optimal for precipitation. Else, precipitates would not have formed so rapidly and without incubation.

It was that evening, as I discussed my laboratory observations with my wife, that the thought of a practical test crystallized in my mind. If I could discover the several factors which govern the phenomenon of precipitation in syphilis, I would know which conditions are optimal for precipitation and which retard precipitation. By utilizing the optimal conditions it should be possible to develop a practical precipitation test in which the results would be obtained in so many minutes.

Factors Governing Precipitation Phenomenon in Syphilis

Let me summarize briefly four basic factors which I found to govern the phenomenon of precipitation in syphilis.

1. *Concentration of Reagents.*—One of the first observations I made was that, for optimal precipitation in syphilis, it is essential to employ the serum and antigen suspension in proper concentration. It was customary in the early twenties to dilute the serum with physiologic salt solution before it was employed with the antigen mixture. I observed that while this dilution does not apparently affect complement fixation results, it markedly affects precipitation results. Not alone must the serum be employed in an undiluted state for maximal precipitation, but the antigen, which is a lipid extract of beef heart, must also be of proper concentration; also, the amount of physiologic salt solution used in the precipitation system must be minimal.

2. *Antigen-Salt Solution Suspension.*—This suspension is prepared by properly mixing the antigen with physiologic salt solution. The antigen is prepared in accordance with a specially improvised technique. The beef heart used for the preparation of antigen must be dried and powdered. The beef heart powder is then first extracted with ether and then with alcohol. To the resulting alcoholic extract, cholesterol is added. This cholesterolized extract must then be mixed with salt solution to produce an unstable antigen suspension. This antigen suspension contains lipid aggregates. These aggregates disperse when in contact with serum. Then, in syphilitic serum, new aggregates appear in the form of a precipitate and in nonsyphilitic serum no new aggregates appear.

3. *Quantitative Relation Between Serum and Antigen Suspension.*—For maximal precipitation results, the ratio between serum and antigen suspension must be optimal for precipitation. A syphilitic serum which may give marked precipitation with a certain quantity of antigen suspension may give no precipitation if the amount of antigen suspension is, for example, doubled.

4. *Agitation of the Serum-Antigen Mixture.*—The fourth basic observation was that agitation markedly influences the formation of precipitates in syphilitic serum with antigen suspension. While strongly positive serum will show flocculation immediately on mixing with an appropriate amount of antigen suspension, weakly positive serum requires agitation for several minutes for the formation of precipitates.

With the above four basic requirements for optimal precipitation, the development of a practical test was a natural sequel. It was like building a house with the foundation and materials available, when all that was necessary was to decide upon the design. I first designed a technique which required several hours of incubation, but I was soon able to replace it by a technique, which has come to be known as the standard Kahn test, which does not require incubation and

in which the results are read several minutes after mixing the serum with the antigen suspension.



Fig. 1. The first serology laboratory of the Michigan Department of Health, in which the Kahn test was developed. The man standing in the rear was a visitor from India (Photograph taken about 1923).

Early Studies on the Author's Test

On July 14, 1923, my first article on the standard Kahn test appeared in the *Journal of the American Medical Association.* In October of the same year I demonstrated the test at the annual meeting of the American Public Health Association in Boston. In that demonstration, which was made before the Laboratory Section of the Association, forty "unknown" serums were examined on the rostrum in front of the audience. The serums were supplied by Dr. William Hinton of the Harvard Medical School. Mr. W. W. Duemling, a medical student at the University of Michigan, at present a dermatologist in San Diego, assisted me in this demonstration. The Kahn results which I reported on these serums were essentially the same as the Wassermann results previously obtained by Dr. Hinton, except that several serums which gave doubtful Wassermann reactions in treated cases of syphilis, gave positive Kahn reactions.

One of the most important aspects of the standard Kahn test is uniformity in results. An essential requirement for uniformity is the standardization of the antigen used in the test. This standardization of antigen was one of the major problems that we turned to after reporting the new test. By 1925, we accumulated sufficient data to publish a monograph on "Serum Diagnosis of Syphilis by Precipitation" (Baltimore: Williams and Wilkins).

Keim and Wile were the first to report on the clinical value of the earlier procedure of the new test. They concluded that the test had basic value in the serum diagnosis of syphilis. With the improvement of the technique of the test, Dr. Wile, the head of the Department of Dermatology and Syphilology of the University of Michigan Medical School, assigned his associate in the department, Dr. Harther L. Keim, to investigate clinically the standardized test. A plan was then worked out between Dr. Keim and myself whereby he would send "unknown" serums from patients in the University Hospital to my laboratory in the Michigan Health Department for examination with the new test. This plan, in due time, led to three published reports. One was based on the serologic examination of 2,600 cases in a study of the diagnostic value of the test. The second was based on the serologic examination of 2,500 cases in a study of the specificity of the test. The third was based on the serologic examination of 1,000 spinal fluids.

Meanwhile, much data accumulated in my laboratory, both by associates and by me, on numerous aspects of the test. These data appeared in twenty-two different articles in various journals by the fall of 1925. These articles were then collected by the late Dr. C. C. Young, the dynamic and progressive director of laboratories of the Michigan Department of Health, into a Michigan

Department of Health reprint for wide distribution. I had the good fortune at that time of having as my assistant, Dr. Pearl L. Kendrick, who was an exceptional and enthusiastic worker. Dr. Kendrick soon left my laboratory to take charge of the Western Michigan Division of the Bureau of Laboratories of the Michigan Department of Health which was established in Grand Rapids, and she has since become renowned particularly in the field of pertussis vaccination.

The Author's Precipitation Procedures

My serologic studies during the past score of years embraced two paths. One was to gain knowledge of the nature of serologic reactions in syphilis. The other was to enlarge the usefulness of serology to physicians by the development of special serologic procedures. These they could employ supplementary to serodiagnostic tests in such cases in which these tests are inadequate in supplying them with needed serologic information.

We will first consider the serologic procedures developed in this laboratory for supplementary use to the standard Kahn test.

The Presumptive Test.—This test is about 10 per cent more sensitive than the standard test. The presumptive test is not intended for use in diagnosis. Its supersensitivity means that it may occasionally give false positives. The presumptive test is of value (1) as a laboratory check on serodiagnostic tests, (2) as a screen test, (3) in the examination of blood donors for blood transfusion, in addition to the standard Kahn test, and (4) in special situations in treated cases in which negative reactions are obtained with serodiagnostic tests; the physician might then wish to determine if a supersensitive test also gives a negative reaction.

The Quantitative Test.—The quantitative serologic titer in syphilis can be obtained on the same basis as the quantitative agglutination titer is obtained in other infections, as, for example, in typhoid fever. The quantitative titer in syphilis is especially of importance in treated cases. A person with syphilis might give a titer of 400 serologic or Kahn units before treatment and a titer of four units some months after treatment has been completed. This marked reduction in the titer would indicate that the treatment had a highly desirable effect on the serologic response of the patient. But if a serodiagnostic test alone were employed, the same patient would have given a 4-plus reaction both before and after treatment, suggesting that the treatment may not have affected the serologic response.

Qualitative Spinal Fluid Test.—The precipitation test with spinal fluid, as is well known, is applicable to the diagnosis and treatment of neurosyphilis.

Quantitative Spinal Fluid Test.—This test gives the quantitative titer of spinal fluid in neurosyphilis similar to the quantitative serum titer.

Micro Procedures.—Several micro procedures were devised to aid in the diagnosis of special cases. Thus (1) A micro serum procedure makes possible a serologic examination with about 0.05 c.c of serum in instances in which it is difficult to obtain a regular blood specimen from a patient. (2) A micro spinal fluid procedure. (3) A micro procedure in the examination of chancre fluid. (4) A micro procedure in the examination of the vitreous humor. These last two procedures have occasionally given positive reactions in the face of negative reactions with serum.

Optimal Zone Reaction in False Negative Cases.—The occurrence of false negative reactions with present-day highly sensitive serologic tests has been puzzling. Studies carried out in this laboratory indicate that these reactions may be due to the narrow reacting zone of serodiagnostic tests. While these tests are adequate in the detection of syphilis in most instances, in others they are not. Hence, we developed this special optimal zone technique applicable to syphilitic persons who give negative reactions with serodiagnostic tests. This technique has two reacting zones in addition to the serodiagnostic zone. The technique is based on the observation that each person with syphilis gives an optimal serologic reaction in a specified reacting zone and that, in some instances, this optimal reaction occurs in reacting zones outside the serodiagnostic zone. The optimal zone reaction is believed to be of special value in determining whether a negative reaction following therapy in syphilis is: (a) a "partial negative," namely, when the reaction is negative with serodiagnostic tests, but positive with the optimal zone procedure, when serologic relapses are to be expected, or

(b) a "complete negative," namely, when the reaction is also negative with the optimal zone procedure, when relapses are not to be expected or at least should be reduced to a minimum.

Quantitative Optimal Zone Reaction.—Studies in this laboratory indicate that a person with syphilis gives the highest quantitative titer in the reacting zone which is optimal to that person. In most instances the highest quantitative titer is obtained in the serodiagnostic zone. In certain instances, the highest titer is to be found outside the serodiagnostic zone. The value of the quantitative optimal zone reaction lies in such cases undergoing treatment in which the regular quantitative technique gives results out of line with expected findings.

Verification Reaction in False Positive Cases.—Studies carried out in this laboratory indicate that true and false positives have their origin in a biologically widespread serologic reaction with lipid antigen, referred to as "universal serologic reaction." This unity of origin of true and false positives helps to explain why it has been impossible thus far to differentiate these positives on an absolute basis.

Yet, the problem of aiding physicians serologically in the diagnosis of false positive reactions is not hopeless if the plan proposed in our first publication of the verification test is widely adopted. Briefly, the test is to be applied to such seropositive cases which, according to clinical and epidemiologic findings, give no indication of syphilis but give indication of false positives. In establishing a final diagnosis in these cases, two possibilities must obviously be kept in mind, namely, that they are either cases of latent syphilis or that they give false positives. In such cases, if the verification test gives a false positive type of reaction, the clinical and epidemiologic findings are corroborated and a final diagnosis of a false positive reaction would seem reasonably safe. If the verification test gives a syphilitic type of reaction, the possibility of latent syphilis must be taken into consideration. In the utilization of this plan in difficult cases, if a dermatologist is consulted, on the one hand, and the verification tests are repeated at relatively prolonged intervals, on the other, the problem of false positives even in such cases would lend itself to a correct solution.

It should be mentioned that five differential techniques embrace the present-day verification test. The reason for this multiplicity of differential techniques is that there are different types of false positives, thus requiring different techniques for their detection.

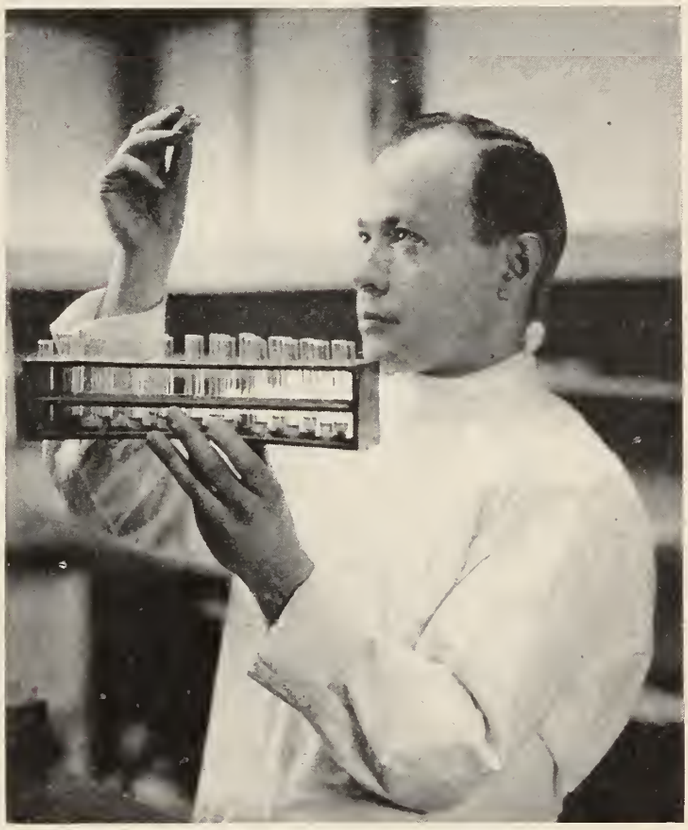


Fig. 2. Dr. Kahn reading his tests (Photograph taken about 1923).

Kahn Reactions with Cardiolipin Antigen.—Dr. Pangborn, working in the laboratories of the New York State Health Department in Albany, isolated a phospholipid from beef heart which she named cardiolipin. She also devised a method for the preparation of purified lecithin. Cardiolipin, lecithin and cholesterol, in proper combination, serve as an antigen in tests for syphilis. This new antigen is being widely investigated, and a number of serologic tests, mostly microscopic slide tests with this antigen, have been published. At the time of this writing, Dr. Pangborn is attempting to improve upon the method of preparation of lecithin. The utilization of purified lipids as an antigen in tests for syphilis has great promise, and further studies should be encouraged. In the present state of knowledge of cardiolipin antigen, one must await results of further investigations.

Universal Reaction with Lipid Antigen.—It was observed that lipid extracts used as antigens in

tests for syphilis, although highly specific in these tests, can be technically employed with serums so as to give positive precipitation reactions without regard to syphilis. Studies with various serologic techniques for eliciting these reactions led us to devise a quantitatively standardized method for comparative studies in health and disease. With this method, serologic reactions have been obtained with serums of all human beings and all animals tested thus far. Because these reactions are so widely manifested they are referred to as "universal" serologic reactions.

Each normal individual shows, within quantitative limits, a distinctive universal serologic pattern. Repeated serologic examinations of the same individual indicate that this pattern remains unchanged under conditions of health. In certain diseases, the pattern undergoes characteristic changes. Thus far, four diseases have been studied serologically with the universal reaction: syphilis, leprosy, malaria, and tuberculosis. The data have not yet been published, but indications are that the reaction is of practical value particularly in the last three diseases. The value of the reaction in other diseases is under investigation.

Nature of Serologic Reactions in Syphilis

When considering the nature of serologic reactions, we must turn to the realm of theory. It is believed that the universal reaction, just discussed, is the forerunner of serodiagnostic reactions in syphilis. A normal person gives a universal reaction of a given serologic pattern. This reaction is removed from the serodiagnostic zone. When the same person acquires syphilis, his serologic reaction assumes the characteristics of a syphilitic serologic pattern, and the reaction embraces the serodiagnostic zone. When he is successfully cured, he reverts to his normal serologic pattern again.

It would appear that the universal reaction represents a natural antigen-antibody reaction with lipid antigen, that lipids liberated in normal tissue wear and tear call forth specific antibody production, and that these antibodies react with lipid antigen in the universal reaction. In syphilis, there is an increase in the liberation of certain tissue lipids; these in turn call forth specific antibodies which give the particular serologic pattern noted in this disease.

Much more remains to be said. As I indicated above, we are dealing in the universal serologic reaction with unpublished data. We have been assisted in the development and studies of the universal reaction during the past two years by the Office of Naval Research, Washington. The field is most promising. It is our hope also that these studies will ultimately open the way toward a better understanding of the nature of serologic reactions in syphilis.

Current Research Investigations

Current investigations embrace: (1) The use of the universal serologic reaction in health and in various diseases in addition to syphilis, such as in tuberculosis, malaria, leprosy, et cetera, and the study of the nature of the reaction. (2) Serologic reactions with purified lipids, especially cardiolipin antigen developed by Pangborn, in relation to reactions with regular tissue extract antigens. (3) Optimal zone and verification reactions with a view of aiding the solution of false negative and false positive problems in the serodiagnosis of syphilis. (4) Serologic and immunologic studies in cancer with a view toward a better understanding of fundamental immunologic aspects of cancer and to find serologic ways and means of aiding physicians in the detection of early cancer.

MSMS

A POOR USE OF WORDS

A point that requires constant emphasis is the prevalent use of the term "organized medicine" by members of the medical profession. It continues to crop up in speeches and articles and in the ordinary conversations of physicians.

There can be no doubt that the term is meant to convey the idea of medical men acting as a group, associated together for their mutual welfare and the advancement of science. There has, however, arisen in the mind of the general public an unfortunate connotation over the word "organized." Recent experiences have shown too often that some organized groups tend toward a narrow self-interestedness that is inimical to the general welfare. It is no wonder that the public's attitude toward them has become one of increasing coldness.

The medical profession has too much at stake to allow the public to become alienated. The use of the term "medical profession" instead of "organized medicine" will help to minimize needless misunderstanding.

Is it too much to hope that medical speakers, medical writers, and doctors in ordinary conversation will discontinue the use of a misleading and damaging phrase? We sincerely hope so.—*New York State J. Med.*, 48:1243, (June 1) 1948.

The Specificity of the Kahn Reaction

By Reuben L. Kahn, M.S., Sc.D., and
Elizabeth M. McDermott
Ann Arbor, Michigan

A BASIC REQUIREMENT for a dependable test for syphilis is that it must be highly specific. It must also be highly sensitive, of course, or else it is no test. But the question of high or low specificity of a test is often controversial because of the difficulty in establishing that a given serologic reaction is a false positive. To help overcome this difficulty, the Health Organization of the late League of Nations called a serological conference twenty years ago, with a view of determining which test for syphilis in use at that time in the medical world stood high in dependability and particularly in specificity. The conference was held at Copenhagen, May 21 to June 4, 1928, and one of us (R.L.K.) was officially invited to attend it with some fourteen other serologists from different parts of the world.

It was a working conference, at which the invited serologists actually performed tests at the State Serum Institute of Denmark. Each serologist was given during the conference, daily, for ten days, 100 "unknown" serums for examination. These serums he examined, either alone or with assistants, in a specially assigned room separated from rooms occupied by the other serologists. He placed the results of his test in a sealed envelope which he turned over to the Secretary of the Conference. In the final tabulation of the results obtained by all serologists, it was found that the Kahn test stood first in dependability.

In 1930, the League of Nations Health Organization invited one of us (R.L.K.) to visit different countries in South America and to attend a similar serologic conference in Montevideo. At this conference also the Kahn test stood first in dependability. The following sentence is taken from the "Conclusions" of the League of Nations report of the Montevideo Conference:

"The majority of serologists taking part in the Montevideo Conference agree that, in the hands of Professor Kahn himself, the Kahn standard test, which (as was the case also at the Copenhagen Conference) proved to be absolutely specific and extremely sensitive, was the best of those demonstrated at the Conference."

Beginning with 1935, evaluation studies on tests for syphilis have been carried out by the United States Public Health Service under the auspices of the American Evaluation Committee on Tests for Syphilis. This committee consists of representatives of the American Society of Clinical Pathologists, of the American Association of Dermatologists and Syphilologists and of the U. S. Public Health Service.

TABLE I. NUMBER OF FALSE POSITIVE REACTIONS GIVEN BY THE STANDARD KAHN TEST IN OFFICIAL EVALUATION STUDIES CONDUCTED FROM 1928 TO 1948
In the Examination of 3740 Nonsyphilitic Donors

Year	Number of Non-syphilitic Cases	False Positive Re-actions	False Doubtful Re-actions	Negative Re-actions	Types of Nonsyphilitic Cases
Studies Carried Out by League of Nation's Health Organization					
1928	434	0	5	429	Malignancy, fever, etc.*
1930	304	0	2	302	Malignancy, fever, etc.*
Studies Carried Out by American Evaluation Committee					
1935	468	1**	4	463	Malignancy, fever, etc.*
1936	100	0	1	99	Normal
1937	100	0	0	100	Normal
1938(1)	96	0	0	96	Normal
1938(2)	444	0	0	444	Tuberculosis
1939	114	0	0	114	Normal
1940	111	0	0	111	Normal
1941(1)	130	0	0	130	Normal
1941(2)	453	0	0	453	Malignancy, fever, etc.*
1942	129	0	0	129	Normal
1943	131	0	0	131	Normal
1944	161	0	0	161	Normal
1945	153	0	0	153	Normal
1946	135	0	0	135	Normal
1947	136	0	0	136	Normal
1948	141	0	0	141	Normal

*With exception of malaria and leprosy.
**This positive reaction was given by all participating methods, and the likelihood is that it was obtained in a case of syphilis.

Table I summarizes the specificity results of the standard Kahn tests in all the official evaluation studies in which the tests were performed by the senior author or in his laboratory. In these eighteen evaluation studies in which 3,740 nonsyphilitic donors were examined, the Kahn test gave one positive reaction and twelve doubtful reactions. The positive reactor was similarly positive with all the other methods which participated in that study, and the belief is that the reaction was most likely specific. The table also shows that since 1937, the Kahn test has not given any false positive or false doubtful reactions in these studies.

No claim is made that the Kahn test is totally free from false positives. These evaluation data are presented because no other test, whether complement fixation or precipitation, has given such a high record of specificity in these evaluation studies.

Miss McDermott is serologist, University Hospital, Ann Arbor, Michigan.

Interpretation of Serological Tests for Syphilis

By H. E. Cope, M.D.

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THE PROBLEMS which have apparently recently arisen in the interpretation of serological tests for syphilis are difficult to understand without some knowledge of the history of the development of these tests. The antigens used in the original complement fixation procedures by Wassermann and Bordet were watery extracts of liver and/or heart from syphilitic fetuses. These proved in clinical trial to be relatively insensitive, and clinical pressure was immediately placed on the serologist to increase the sensitivity of these tests.

From then until the very recent past, every modification of the complement fixation procedure, and to a large extent, the development of flocculation procedures has been predicated largely on this same demand for increasing sensitivity in the testing for syphilis. Extraction of heart muscle with ether and alcohol, the addition of increasingly large amounts of cholesterol, the addition to base antigens of the acetone-insoluble portions of the ethereal extracts, preliminary fixation at increasingly long periods of time at ice-box temperatures, all had as their primary purpose increased sensitivity. The nineteen-twenties saw the development and popularization of flocculation tests for syphilis such as the Meineke, Kahn and Kline tests, only because these tests demonstrated an over-all sensitivity as great or greater than complement fixation tests using a simpler technique. Throughout all this developmental period the emphasis was on the necessity for increasing the sensitivity of the testing procedures.

The international serological conference[5] at Copenhagen in 1928 and subsequent international conferences did not serve to emphasize anything but the relative sensitivity of various tests in the hands of the author-serologists. Although the performance of the tests was rated in terms of both sensitivity and of specificity, the method of selection of sera to be included in the test group was such as to throw out of the compilation all positive tests obtained by the majority of the participants in the study when unsubstantiated by clinical evidence of syphilis. In substance, the significant results as far as specificity is concerned have been excluded from consideration in these surveys and, in fact, in most of the subsequent surveys of serological accuracy. The reported specificities of these tests have actually been reports of the technical accuracy of the individual laboratory in which the tests have been made. One has only to review the results of any one of the annual evaluations of serological tests in the laboratories of the state health departments to realize that this is true. The recorded specificity in the vast majority of the laboratories ranges from 99 to 100 per cent. In practice, however, problems in interpretation of positive serological results seem to arise with greater frequency than statistics would indicate.

There have been a number of reasons for the recent increasing recognition that a problem may exist in the interpretation of the significance of a positive serological test. This is not a new problem. Serological tests have not changed in specificity over the past few years. What has changed is essentially the group under test. Until the late thirties, serological tests for syphilis were largely performed on sick patients. Positive tests were usually accepted as evidence that the individual's illness was associated with syphilis. At the present time over half of these tests are performed on essentially well people, either because of premarital or prenatal laws or as part of a pre-employment physical examination. Although it has long been known that certain diseases were often associated with false positive tests for syphilis, the real problem, however, is the occurrence of an appreciable number of unexplained and in many instances apparently unexplainable positive reactions in this large group of apparently well people.

How common are such unexplainable false positives? We know of no accurate statistical report as to their incidence in civilian practice. The only controlled studies seem to be those of young males in the military and allied services. Wolman,[7] for instance, found 783 individuals with a positive Kahn test in a group of 82,070 enrollees in the Maritime Service. Further study led to a diagnosis of syphilis, congenital or acquired, in 47 per cent of these individuals. Forty per cent had

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only a single positive blood test and 13 per cent had repeated positives apparently not of syphilitic origin. In this series there was an over-all incidence of 0.9 per cent positive reactions. Of the positives, however, less than half proved to be due to syphilis. Shaffer[6] reports that a definite diagnosis of congenital syphilis could be made in only 17 per cent of a group of 150 servicemen found to have positive serological test at the time of their separation from the service. In a group of 508 separatees Rosenthal and Sobel[3] could establish the presence of syphilis in only 5 per cent. The compiled statistics of the experience of the nationwide co-operating group as released by the Public Health Service are not quite so discouraging.[2] Of 62,923 separatees with no history of previous treatment for syphilis, but with positive or doubtful tests upon separation, 66.4 per cent proved to be not infected. In a similar group of 52,180 separatees giving a history of having been treated for syphilis, and with positive or doubtful tests upon separation from the service, 69.3 per cent were found to be not infected. It must be remembered, however, that cases of syphilis had presumably been combed out from this group through the preinduction examinations, that syphilis within the group was probably largely recently acquired syphilis and, therefore, that these results probably did not accurately reflect the probability of any given positive blood test being indicative of syphilis. They did serve, however, to emphasize the necessity of careful scrutiny of any positive test not corroborated by clinical history or physical examination.

During the past few years a number of serologists have attempted to develop serological techniques which would differentiate positive tests due to the presence of syphilis from "biological" positives. The consensus of opinion among syphilologists[4] seems to be that the results of these tests cannot be completely relied upon in the solution of this problem. Neurath[1] and his associates have recently applied an entirely new technique to this problem with results which are at least hopeful. The technical procedure, however, seems rather complicated for application in the average serological laboratory. There does not, therefore, appear at the moment to be any completely reliable and easily available method by which positive reactions due to syphilis can be immediately differentiated in the laboratory from positive biological reactions.

When Panghorn and her associates first described the preparation and the methods for use of a simplified cardiolipid antigen in serological testing, everyone hoped that this might be the answer to the problem. A large number of different techniques have been proposed for the use of this type of antigen. They are still under study. Experience to date seems to indicate that the number of false positives is decreased when this antigen is used. As experience accumulates, however, there is increasing evidence that false positives may be obtained with this technique also. There also appear to be technical problems in the preparation of the antigen which have not been completely solved. The status of serological testing with cardiolipid antigens at the moment seems to be much the same as the status of flocculation tests in the 1920s. Accumulated experience will soon evaluate its place in serological procedures.

If laboratory aid is not immediately available then, how does one recognize a false positive and set about to differentiate it from a positive due to syphilis? First and foremost, a positive test should be correlated with other evidence of syphilis. A careful history, both personal and epidemiological, and a physical examination will in some instances serve to establish the validity of a positive report. In the absence of physical or epidemiological evidence of syphilis, the character of the serological reaction itself may suggest the possibility of false reaction. As a rule, false reactions tend to be of low titre. In our experience well over 50 per cent have been either doubtful or had a titre of 1:1. Doubtful and weak positive reactions should, therefore suggest further observation. Tests should be repeated. Immediate quantitative estimation of the titre or amount of reagin present will furnish a base line for evaluation of subsequent tests. Testing by other procedures is often helpful. False positive reactions often tend to be positive by flocculation techniques and negative by complement fixation, or vice versa. In many instances, however, the answer to the problem is to be found only in repeated testing over a period of time. To yield maximum information such tests should be of the quantitative type. In some instances false positive reactions seem to be very evanescent in character; some disappear entirely or decrease markedly in titre with in a relatively few days. Others may persist over periods as long as three and occasionally six

months. It may take considerable courage on the part of a physician and considerable patience on the part of the patient to finally arrive at a definite laboratory answer to the problem. Over a period of time, false postive reactions show fluctuating or decreasing reagin titre. When the reaction is due to syphilis, the titre of reagin as a rule either stays at a constant level or increases. The validity of these observations, however, is predicated upon the withholding of treatment for syphilis. Once treatment is instituted, one cannot interpret the significance of subsequent tests. One probably should be cautious in attempting to evaluate the significance of serological follow-up when penicillin is used in the treatment of intercurrent infection.

It might be wise to pause at this point for a moment and define or explain some of the terms which have been used. Reagin is the antibody-like substance in blood serum or spinal fluid which reacts with the test antigen to give a positive flocculation or complement fixation test. A quantitative test is essentially a series of flocculation or complement fixation tests in which the serum is serially diluted until the amount of reagin becomes so dilute that a negative test is obtained. The titre of a quantitative test is the highest dilution of serum or spinal fluid upon which a weakly positive test is obtained. The quantitative Kahn test may be reported either as a titre, that is the final dilution of serum yielding a positive result, or in terms of Kahn units. Kahn units are obtained by multiplying the serum dilution by four. For example, a serum positive at a dilution of one to eight is considered to contain 32 Kahn units of reagin.

The discussion so far has been largely on the problem of false positive tests for syphilis. In very early syphilis and to some extent also in certain types of late syphilis, the reverse may be true. A blood test is not a reliable or satisfactory tool for the diagnosis of early primary syphilis. This test will be positive in less than 25 per cent of individuals with primary syphilis of less than seven days' duration. A darkfield examination of the exudate from the lesion is much more reliable at this stage of the disease. It is only when from five to six weeks have elapsed that a negative blood test can be considered as of significance in the differential diagnosis of genital lesions by laboratory means. The interpretation of the significance of serological tests in certain types of late syphilis similarly needs to be guarded. Tabes dorsalis, for instance, is frequently associated with a negative blood test. Serological tests in paresis, on the other hand, are always positive. Occasionally, late cardiovascular and osseous syphilis may be present and the blood test be negative. When central nervous system syphilis is suspected and the blood test is negative, examination of the spinal fluid may be of further aid. The laboratory has no additional aids to offer in the problem of diagnosis of late visceral syphilis except in the occasional instance in which biopsy may be practical.

The serological diagnosis of syphilis in the newborn also has presented problems. Some of these problems are inherent in the type of specimen usually submitted to the serologist for examination. Cord blood specimens are easy for the physician to obtain but technically extremely difficult for the serologist to handle. The results, as a rule, are not reliable. Both false positive and false negative results may be obtained when this type of specimen is examined. Even in babies born of mothers known to have syphilis, a problem in interpretation of a positive test on the baby may exist. In the absence of clinical evidence of syphilis in the baby, two possibilities may exist. The baby may have congenital syphilis which is asymptomatic at present, or the baby may simply be a temporary carrier of reagin transmitted from maternal circulation to the fetus through the placenta. In this instance reagin behaves in a manner very similar to antibodies transmitted from mother to baby. Excretion is fairly rapid and repeated quantitation will show a decreasing reagin titre. In the presence of syphilis, the titre, however, remains constant or increases.

Our information regarding the results of serological testing of spinal fluids is far less complete than it is in reference to the testing of blood specimens. We have, for instance, little or no accurate information regarding the occurrence of biologic reactions in spinal fluid specimens. We do recognize the existence of technical difficulties in the accurate performance of both complement fixation and flocculation tests. There are, however, supplementary or auxiliary tests on spinal fluids which are often of considerable aid in the final interpretation of positive serological results. An increased cell count indicating inflammation is of definite corroborative importance. A normal cell count, however, can be considered of im-

portance only when the count has been made promptly after withdrawal of the fluid. Increased total protein, again, can be considered as evidence of active inflammation. It probably should be mentioned that there are a number of different methods in current use for the determination of protein. These do not all yield comparable results. The average normal levels which may be expected with the method employed should, therefore, also be known. The problem of interpretation of the significance of colloidal gold reactions seems more and more insurmountable. A positive colloidal gold reaction of any type is not diagnostic *per se* of central nervous system syphilis. There is no correlation between the type of gold curve and the clinical type of luetic involvement, nor does a negative gold curve definitely rule out the possibility of asymptomatic central nervous system syphilis.

Summary

1. Both the clinician and the laboratory recognize that false positive tests for syphilis occur with a fair degree of frequency.

2. Although the association of false positive tests with certain diseases is common knowledge, many of these reactions are found in practice today in essentially normal well individuals.

3. There does not appear to be at the present moment any single test which will immediately differentiate false positive reactions from those due to syphilis.

4. The significance of a positive serological test must be evaluated in terms of clinical history and examination, repeated serological testing by various techniques and repeated quantitative estimation of amount of reagin in the blood serum of the individual under study.

5. Progress is being made in the development of newer and somewhat more accurate techniques for serological testing. At the moment these, however, await final evaluation.

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Treatment of Early Syphilis

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THERE ARE STILL so many gaps in our knowledge concerning penicillin, that even though it has been critically and extensively studied for more than four years, one as yet can not dogmatically set up a standard adequate treatment schedule for early syphilis. We are in much the same position as we were several years after the introduction of arsephenamine, but fortunately there now exist in this country the facilities and opportunities for a more accurate and rapid appraisal of penicillin than prevailed at any time for the arsenicals. Conservative investigators agreed with Stokes[6] when in 1943 he said, "it will take a year to *guess,* two years to *intimate,* five years to *indicate,* and a decade or more to *know* what penicillin does in syphilis."

One of the principal reasons for this time lag is that the evaluation of therapy in syphilis must be carried out on a different basis than in most other diseases. Here it must be done in reverse. If a patient with syphilis is treated and subsequently remains well for a year or two, we cannot with absolute certainty say he is cured, but if any manifestation of the disease reappears, it is evident that treatment has failed. Therefore, in order to draw conclusions in a reasonable period of time we are forced to compare the effectiveness of different treatment schemes according to the relative incidence of failure rather than the percentage of cures.

Early detection of treatment failure is possible only in early syphilis, and the clinical evaluation of any new antisyphilitic agent or schedule must be initiated at this stage of the disease. By early syphilis we mean acute acquired syphilis, namely, seronegative and seropositive primary, secondary, recurrent secondary, and latent syphilis of less than four years' duration.

The recurrence of lesions of syphilis, or strongly positive serologic tests after previous negativity, the persistence of strong positive tests after treatment or the development of clinical or serologic evidence of nervous system involvement, all obviously indicate failure. The frequency of such events after the treatment of syphilis with arsenic and bismuth, and now with penicillin alone or in

combination with heavy metals, has long been the basis for the determination of the value of antisyphilitic drugs and of the most effective methods for their administration.

Since the advent of modern therapy of syphilis, there have been three nationwide studies which have done much to evaluate drugs and methods, and to standardize time dosage schedules. The first of these was the Co-operative Clinical Groups[7] (1930-1935) evaluation of the results of standard therapy of weekly injections of arsphenamine and heavy metal. Previous to this investigation, there was no semblance of a uniform treatment schedule in syphilis. In fact, almost every clinician had his own idea as to what constituted adequate treatment. The Co-operative Clinical Group did much to bring order out of chaos and for the first time stressed the necessity of continuous treatment as opposed to interrupted courses then in vogue.

The second was the field study evaluation of massive arsenotherapy conducted with the New York and Midwestern groups of co-operating clinics[8] that took place during the ten-year period 1933-1943. The best results were secured by the original slow drip administration of neoarsphenamine, but administered in this manner, the drug was found to be too toxic, and its discontinuance was recommended. The next best results were obtained by multiple injections of an arsenoxide plus typhoid vaccine. There was little difference observed with mapharsen by slow or rapid drip, or by multiple injections.

Since 1943 a third well-co-ordinated investigation to determine the most effective method of utilizing penicillin in the management of syphilis is being conducted on a large scale by civilian investigators under the direction of the National Research Council. This study was initiated shortly after Mahoney, Arnold and Harris[4] in June, 1943, reported successful results with penicillin in four cases of early acquired syphilis, after having demonstrated its value in syphilis of the rabbit. A new era in the treatment of this protean disease thus was foreshadowed. In view of the practically nontoxic nature of penicillin, the work of these investigators appeared to point the way to the long-sought goal of a rapid and safe treatment for early syphilis. In May, 1946, the material from the Penicillin Panel[1] was summarized, and it appeared, at the time, that the position of penicillin in the treatment of syphilis was settled. More than 11,000 patients with early syphilis had been treated with a variety of treatment schemes and had been observed for over a year. The results led to the development of certain principles of penicillin therapy upon which most of our subsequent treatment has been based.

More recently the results of this study have been reviewed again, with the number of cases increased to 15,000 and the period of observation to almost two years. Most of the conclusions of the first release seem to have been wrong. The total dose apparently was of little consequence, the same results being obtained with anything from 1.2 to 10 million units. It apparently made little difference whether the injections were given at intervals of two, four or six hours, and the time of treatment may be four, seven or fifteen days. The report frowned upon combining arsenic or bismuth with penicillin. The most alarming conclusion from this treatment survey, however, was that the total incidence of failure after penicillin in secondary and early latent syphilis was almost 30 per cent, no matter what scheme of treatment was used. This is a poor record indeed, in comparison with many of the older treatment regimes with arsenic and bismuth. However, in view of more recent information, the over-all result of penicillin therapy in early infections undoubtedly is better than 30 per cent failures, since the older data covered a period when commercial penicillin contained large amounts of penicillin K. This now has been corrected with the almost universal use of crystaline penicillin G, which is highly destructive to the spirochete.

In spite of reported comparative high failure rate in secondary and early latent syphilis, we can justify the use of penicillin on the basis of two factors, which cannot be expressed in figures.

The first of these is toxicity. Penicillin is almost completely nontoxic and thereby differs from all other antisyphilitic agents which are essentially dangerous. Secondly, penicillin treatment can be completed within a period of days so that practically every patient who starts the therapy finishes it.

The only type of treatment that competes with penicillin in time of administration is intensive arsenotherapy, where curative doses of arsenic are administered in a period of five to ten days. The risk of this treatment is exceedingly high, and although the failures are few among those who

survive, the over-all death-rate of 1/400 practically eliminates this type of therapy.

On the other hand, experience has shown that the older treatments fail largely because only about 35 per cent of those who start ever go on to completion. Those who complete the older treatment are probably better off than those who take penicillin, but for those who fall by the wayside, penicillin would have been infinitely better.

On the grounds, therefore, that penicillin therapy can be completed in every case in which it has been started and that its administration is practically devoid of danger, I think it is still the treatment of choice in early syphilis in spite of its relative high rate of failure. This opinion is based partly on the fact that an initial failure in treatment does not indicate the impossibility of final cure. There is no evidence that syphilis does become resistent to penicillin, and the great majority of patients who have required retreatment have responded perfectly well to subsequent courses of penicillin or penicillin and heavy metal, and have, for the most part, remained well. However, because of the frequency of relapse after penicillin, it is vital that patients treated with it be followed with great care, both clinically and serologically. They should have monthly quantitative serologic tests for the first year and at three-month intervals during the second year.

Spinal fluid examination is a must and should preferably be done at the onset of treatment and repeated at the end of the twelve-month observation period. Under no circumstances should a patient be declared free of the disease until spinal fluid confirmation is established. When a physician adopts penicillin therapy for early syphilis, he assumes the responsibility for careful follow-up and periodic post-treatment observation on all patients so treated. Furthermore, in my opinion, the physician's responsibility does not stop here but includes the reporting of these cases just as with any other contagious disease, as well as a serious effort to gain contact information himself or to accept the assistance of trained personnel from local health departments.

The value of penicillin in the management and control of syphilis is established beyond a doubt, but the time-dosage schedule and the preferable type of preparation remain for the future to settle. After its parenteral injection in aqueous solution penicillin is rapidly absorbed and promptly excreted in the urine. Accordingly, many workers have sought to prolong this action of the injected medicant. All the proposed methods are either absorption-delaying or excretion-suppressing. At present the most successful method of prolonging therapeutically active levels is the admixture of crystaline G penicillin suspended in peanut oil and beeswax (POB) developed by Romansky and Rittman.[5] Eagle[3] found this preparation more efficient, unit for unit, in the treatment of rabbit syphilis than the aqueous solution. This type of preparation has now had sufficient clinical trial so that it may be recommended for the ambulatory treatment of early syphilis. Eagle[2] and his coworkers have also studied the use of oxophanarsine hydrochloride given in conjunction with penicillin in the treatment of experimental rabbit syphilis. The two drugs were so much more effective than either alone, that a synergistic rather than a merely addative effect was suggested. While the combination of penicillin with arsenoxide and/or bismuth subsalicylate does definitely increase the risk of reaction, the cumulative percentage of failures at the end of a year is materially reduced.

The fluid state of the treatment of syphilis, since the introduction of penicillin, makes it impossible to outline an ideal method of procedure at this time. It should be emphasized that the following suggestions for the use of penicillin in early syphilis represent a combination of medical desirability and expectancy. They are based on information at present available, are only tentative and are subject to revision as information accumulates. We feel however, that the time has come, when we can recommend penicillin in oil, in combination with an arsenoxide and bismuth for ambulatory treatment. Furthermore, with the following schedules we believe we can expect a high percentage of cures, with comparatively few serious reactions.

Seronegative Primary Syphilis

15 daily injections of 300,000 units of penicillin in oil. (total 4.5 M. U.)

Seropositive Primary Syphilis

15 daily injections of 300,000 units of penicillin in oil. (total 4.5 M. U.)

Followed by:

2 injections of arsenoxide (mapharsen) and 1 injection bismuth salicylate per week for 8 weeks.

Secondary Syphilis

15 daily injections of 300,000 units of penicillin in oil. (total 4.5 M. U.)

Followed by:

2 injections of mapharsen and 1 injection of bismuth per week for 8 weeks.

10 daily injections of 300,000 units of penicillin in oil. (total 3.0 M. U.)

Recurrent Secondary, Early Latent or Early Asymptomatic Neurosyphilis

15 daily injections of 300,000 units of penicillin in oil.

Followed by:

2 mapharsen injections and 1 bismuth injection per week for 12 weeks.

15 daily injections of penicillin in oil, as above.

The most common reaction is the unimportant Herxheimer reaction which occurs in 50 to 60 per cent of all cases of early syphilis, in varying degrees of severity. Urticaria and erythema multiforme-like eruptions, occasionally bullous, together with the so-called drug fever, are less frequent complications. Rarely is it necessary to discontinue treatment.

Failures will nevertheless occur, and the physician should be on his guard so that treatment may be reinstituted immediately under the following circumstances:

1. Sudden increase in quantitative titer. Such change usually anticipates the appearance of active lesions.
2. Clinical relapse with objective skin or mucous membrane lesions.
3. Reinfection—approximately five to ten per cent of relapse are held to be reinfections (ping-pong syphilis).
4. Serologic or clinical evidence of neurosyphilis.
5. Seroresistance.

(a) When there is little or no effect on the serologic titer. Persistence of high serologic titer over six months (not twelve), with no trend toward reversal, portends relapse and requires retreatment.

(b) Where the titer declines toward negative but never quite reaches it. If at the end of a year the serologic test is still positive and the titer above four dilution (16 Kahn units), retreatment should be instituted.

There is no experimental or clinical evidence to suggest that the treponema pallidum does become resistent to penicillin. Treatment therefore should be reinstituted with schedule No. 4 with two courses of 4.5 units of penicillin separated by two weekly injections of mapharsen and one of bismuth for twelve weeks.

Conclusions

1. The value of penicillin in the treatment of early syphilis is established beyond doubt.
2. Incidence of failure with penicillin alone is high in seropositive early syphilis.
3. Except in seronegative primary syphilis, combined penicillin, an arsenoxide and bismuth are recommended for ambulatory therapy.
4. Final time-dose schedule of treatment and the ideal type of penicillin preparation remain for the future to settle.

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INTERESTING STATISTICS

A recent analysis of 100,000 surgical benefit claims of all ages made by a committee of the Actuarial Society of America provides a number of interesting statistics.

Not all surgery is performed in hospitals: 2 per cent of operations on men were performed out of the hospital; 16 per cent for children; and 11 per cent for women.

The average amount paid for out-of-hospital claims was less than one-third that for hospital surgery.

It was found that for an appendectomy 30 per cent of the doctors charged less than $100; 50 per cent, less than $125; 80 per cent, less than $150; and 90 per cent, less than $165. Charges were generally higher for men employes than for women, thus reflecting the general practice of suiting fees to the ability to pay.

Surgical fees were highest on the west coast, with California leading them all. They were next highest in the middle Atlantic states and lowest in the south Atlantic states. Eight operations accounted for most of the surgical claims. These were: tonsillectomy, appendectomy, benign tumor or cyst, hemorrhoidectomy, fracture, hysterectomy, herniotomy, and dilation or curettage.—*Connecticut M. J.*, September, 1948.

Syphilis, Marriage and the Public Health

Premarital Examination and the Practicing Physician

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THE PROBLEMS OF syphilis and marriage are so entwined with each other and the public health that no discussion of any one aspect is complete without discussing all three. There is hardly a general practitioner of medicine in the state of Michigan who does not at some time or another have persons presenting themselves to him for a premarital examination. In compliance with the Michigan Premarital Physical Examination Law, the physician examines the individual and takes a specimen of blood for serologic testing. At some time or another he will have reported positive results, ofttimes to his own surprise. The physician and the patient are then concerned with several things: First of all, does the person have syphilis, or is this a false positive serologic test? If the physician decides after repeated tests and further examination that the patient does have syphilis, should he be permitted to marry? If he believes his patient to be eligible for marriage, what is involved in accomplishing this?

The two chief factors involved when considering syphilis in connection with marriage are (1) the danger of infection of the marital partner, and (2) the danger of infection of the offspring. The possibility of a diseased person transmitting his infection to the partner in marriage is dependent upon (1) the duration of the infection, and (2) the amount, type and regularity of the treatment received by that person. The early finding of cases and the institution of treatment not only prevent the spread of infection but will make such person eligible medically and legally for future successful marriage insofar as syphilis is concerned.

The physician has several possibilities to consider before making a decision upon finding positive evidence of syphilis in a marriage applicant. This includes not only the matter of treatment but also the effects of the disease itself due to the shortening of life, incapacitation and reduced earning power of the infected partner. These dangers are equally as hazardous to such a marriage as the disease itself. Other considerations in such a situation are the birth of syphilitic offspring, possible miscarriage or stillbirth. Specifically the physician must summarize the status of the disease of the applicant, the duration of his infection, and the amount and type of any previous treatment, in order to come to a decision and draw a justifiable conclusion.

Requirements for special medical certificates are based upon recommendations of the Venereal Disease Control Committee of the Michigan State Medical Society and are as follows:

1. *Early Syphilis*—All patients with early syphilis (less than four years' duration) must have thorough treatment, i.e., thirty intravenous arsenicals and forty intramuscular heavy metal injections. If intensive therapy is used, the patient must complete one year's satisfactory observation before application for special dispensation will be considered. Such observation entails frequent quantitative serologic tests and physical examinations for signs of syphilis. The patient must have had no evidence of clinical or serological relapse during this time.

2. *Late Syphilis*—All patients with late syphilis (more than four years' duration) should have a minimum of twenty arsenicals intravenously and twenty heavy metals (bismuth) intramuscularly or adequate penicillin therapy. Patients who receive intensive treatment for late syphilis are not required to complete observation before marriage since infectious relapse is not likely.

The above requirements have been modified to the following extent:

I. Factors which may decrease the amount of treatment required:

(a) Persons with late syphilis who are known to have had their infection for many years, and are more than fifty years old, may be considered for special certification, even without treatment. The female marital partner, however, to be certified in this classification must be incapable of bearing children through either physiologic or surgical menopause.

(b) Proven congenital syphilis.

(c) *Demonstrated* pregnancy. Special dispensation certificates may be issued in such cases regard-

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less of the presence of venereal disease in either or both parties to the proposed marriage. In such cases, however, the indicated treatment should be arranged for and satisfactory assurances given that it will be carried out.

II. Factors which may increase the amount of treatment required:

(a) A history of clinical or serological relapse will increase the amount of treatment required above.

Under the premarital law it is mandatory that the partner should be informed of the disease so that he may accept or reject the risk involved in the marriage of an infected person. Syphilis may modify the earning capacity of the husband, it may determine the amount of life insurance that can be obtained, and there is also involved the ability of the wife to earn the living for the family in case of disaster. It is certainly justifiable to inform the partner when one considers the potential catastrophic outcomes if this is not done, such as transmission of the infection to the noninfected partner, the lack of an opportunity for the noninfected partner to accept or reject the risk involved, the difficulty of protecting offspring if the wife is unaware of possible infection during her pregnancy, the possibility of divorce and break-up of a family if knowledge of the infection is gained subsequent to the marriage.

During the three-year period 1945 through 1947, there were 198,456 marriages in the state of Michigan. During this same period there were requests for 2,772 applications for special medical dispensations, which represents a rate of 14 per thousand marriages. Of the applications received, 86 per cent were approved as eligible for marriage under the provisions of the Michigan Premarital Law. In other words, 14 per cent of the applications for special medical dispensation did not fulfill the minimum requirements for marriage in this state. Table I shows the marriages in Michigan, the number of applications received and approved in the year 1945, 1946 and 1947:

TABLE I

year	Total Marriages	No. of Applications Received	No. of Applications Approved
1945	48,329	698	563
1946	78,808	1,082	889
1947	71,319	992	929
Total	198,456	2,772	2,381

The operation of the premarital law requires that the physician request special dispensation for all applicants having a positive serologic test, regardless of whether he believes the test to be true or a false positive biologic test. It is also necessary to request special dispensation for all previously treated cases of syphilis regardless of the present serologic status. This procedure has apparently not been clearly understood by a number of physicians, with the result that they have unwittingly violated the law.

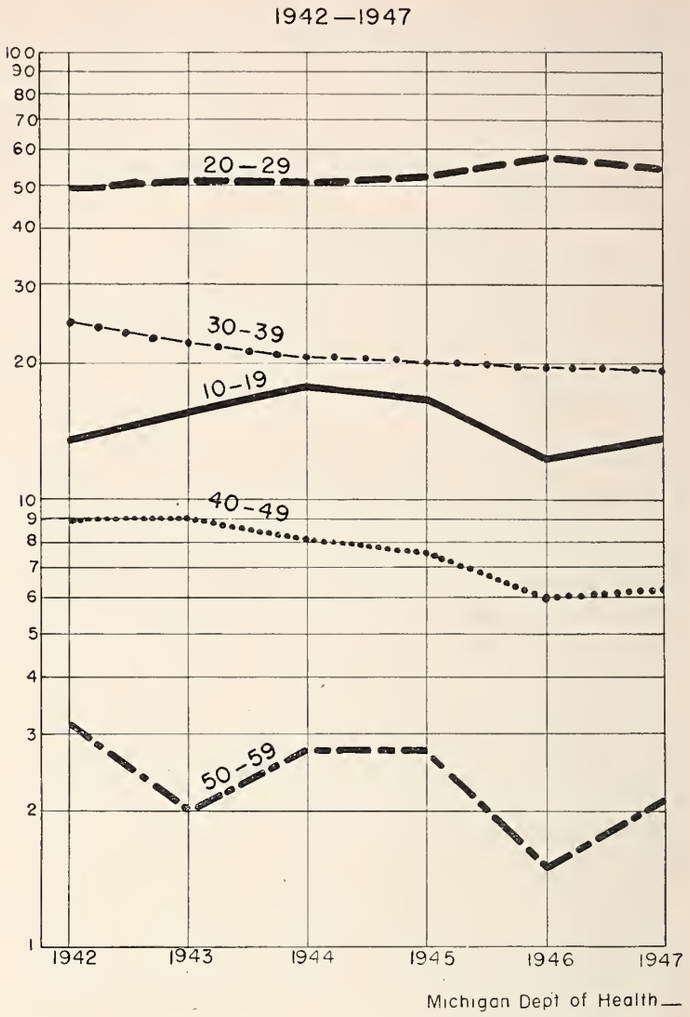


Chart 1. Primary and secondary syphilis reported in Michigan. Per cent by age groups and year for 1942-1947.

Veneral Disease and the Practice of Medicine

The control of the venereal diseases, as well as other communicable diseases, is a basic health department function. Most of the health departments' efforts in this respect are confined to activities designed to discover all infectious cases in the community and to see that they are placed under treatment. The diagnosis and treatment of the individual case of venereal disease is and should be a function of the practicing physician.

Recent advances in the treatment of both syphilis and gonorrhea are making it possible for the practicing physician to assume more and more

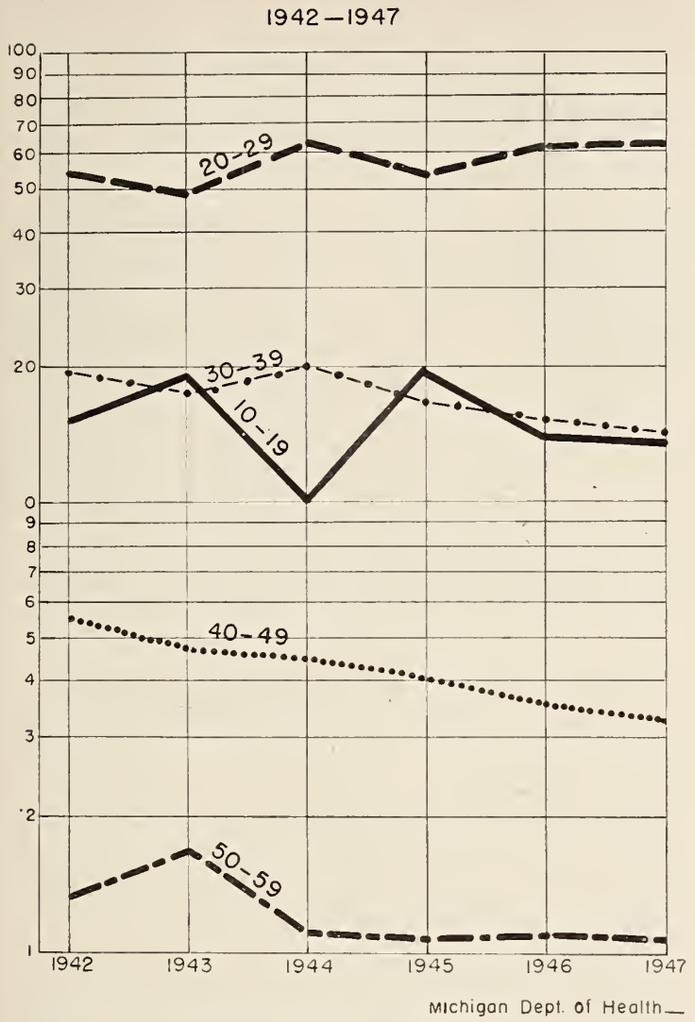


Chart. 2. Gonorrhea reported in Michigan. Per cent by age groups and year for 1942-1947.

of this responsibility. It has now been conclusively shown that gonorrhea can be clinically and bacteriologically cured in 90 to 94 per cent of the cases with a single injection of 300,000 units of penicillin in oil and beeswax. Table II shows the reported cases of venereal disease in Michigan by private physicians and clinics during the year 1947. It is interesting to note that the clinics reported 52 per cent of the syphilis cases and 64 per cent of the gonorrhea cases.

TABLE II

Syphilis	Clinics	Private Physicians	Total
Primary & Secondary	1,787	1,357	3,144
Early Latent	2,585	1,083	3,668
Late & Late Latent	3,070	3,049	6,119
Congenital	269	233	502
Not Stated	303	1,540	1,843
Total	8,014	7,262	15,276
Gonorrhea			
Total	7,080	3,909	10,989

Charts 1 and 2 show the incidence of primary and secondary syphilis and gonorrhea since 1942 by age groups.

Although it is still too early to draw any final conclusions, a great deal of evidence has accumulated which would indicate that early syphilis can be satisfactorily treated on an out-patient basis with daily injections of penicillin in oil and beeswax for a period varying from eight to fifteen consecutive days. Should future evaluations prove as favorable as presently indicated, it would prove a boon to the patient, the physician and the community. Under the old schedules of out-patient treatment of early syphilis utilizing the arsenicals and heavy metals, some fifteen to eighteen months of weekly injections were required. Aside from consideration of relative toxicity, this method of treatment had definite public health disadvantages: Only 25 per cent of those started on such schedules completed treatment, and less than 50 per cent had sufficient treatment to render them permanently noninfectious. The other 50 per cent remained as actual or potential sources of infection in the community. In contrast, using the newer intensive out-patient schedules, about four out of five complete treatments, and on an in-patient basis, practically all complete the entire treatment.

As a result of the developments in treatment, there probably will be a greatly decreased need for syphilis treatment clinics *per se*. Most of the clinics have become largely diagnostic and referral centers. With caseholding becoming a minor problem, health departments will concentrate their efforts in casefinding so that practicing physicians can expect to have more and more syphilis suspects and cases referred to them for diagnosis and treatment. This trend should be encouraged, and in the long run definite advantages should accrue not only to the physician but to the public. However, it also places additional responsibilities on the physician. The greatest weakness in the venereal disease control program today is the paucity of contacts on private physicians' cases. The community in which he practices can and should expect the physician not only to diagnose and treat venereal disease but to determine the contacts of his patients and see that they are placed under treatment. This can be accomplished either on his own initiative or through the assistance of the health department. Only in this way can the chain of infection be broken. During the year 1947, clinics reported

(Continued on Page 1110)

The Treatment of Syphilis in Pregnancy

By Stephen F. Horne, M.D., and
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FROM THE VIEWPOINT of preventive medicine, syphilis in the pregnant woman stands next in importance to acute infectious syphilis. The importance of the prevention of congenital syphilis by adequate treatment of the mother before or during pregnancy is well known by everyone. The following figures serve to emphasize this fact. In the untreated syphilitic mother, the incidence of stillbirth is eight times more frequent. During the first week of life, infant mortality due to congenital syphilis is three times as great as that in the population at large. By the end of the first year of life, four out of every ten children born to untreated syphilitic mothers will have perished, and at least one-half of the living are infected with the spirochete of syphilis (Fig. 1). Congenital syphilis is a preventable disease and could be largely eliminated by the frequent routine use of diagnostic blood serological tests throughout pregnancy and the adequate treatment of the syphilitic mother during pregnancy.

The requirements for ideal syphilotherapy in pregnancy may be listed as follows: (1) a drug with a high spirocheticidal index, but with no serious toxic effects, (2) one which prevents the transmission of the disease from mother to fetus or, if transmission has occurred, produces resolution of the process in the child *in utero* regardless of the stage of pregnancy in which it is given, (3) one which gives adequate treatment for the mother, and finally (4) a drug which can accomplish these aims during a short period of treatment. It is obvious that, prior to the advent of penicillin, we had no therapeutic remedy which was ideal for use in treating the syphilitic mother.

Bismuth, mercury and the iodides must be given over a long period of time and have spirocheticidal indices which are too low. Consequently, one cannot depend upon these drugs to control adequately the mother's infection or to prevent or "cure" the disease in the fetus. The trivalent arsenicals, particularly mapharsen, fulfill the requirements much better. However, these drugs are toxic and, before the use of massive arsenotherapy, had to be used over relatively long periods of time. Moreover, with the exception of the continuous drip methods, if treatment was started after the fifth month of pregnancy, the outcome was not predictable. The results of treatment with massive arsenotherapy were good, but its use was discontinued by most workers because of its toxicity.[1] At the present time the use of BAL would make the toxic reactions less severe.

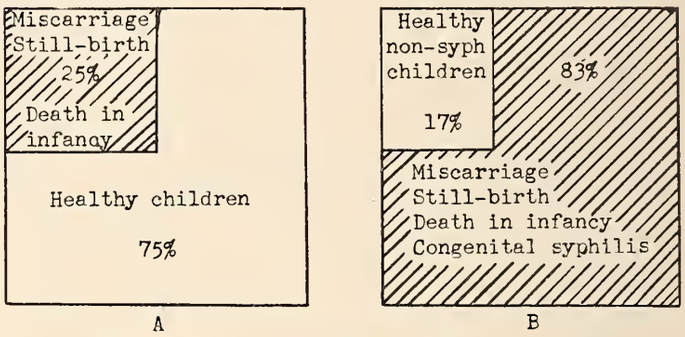


Fig. 1. Effect of syphilis on pregnancy. (A) Outcome in absence of maternal syphilis. (B) Outcome in presence of untreated maternal syphilis. (Modified after Morgan: J.A.M.A., Jan. 28, 1939).

Numerous observers attest the superiority of penicillin over all other methods of treatment for syphilis during pregnancy. Only a few representive reports will be given. Speiser and his associates[10] report the results obtained in the treatment of 259 patients. Various schedules were used, including one using arsenoxide. One hundred and forty-nine patients were treated during pregnancy. One hundred and twenty-three had early infectious syphilis and twenty had latent syphilis. Unsatisfactory results in nine cases (6 per cent) were attributed to syphilis, including three cases (2 per cent) of congenital syphilis and six abortions. Eighty-six pregnancies in eighty-four mothers were treated prior to pregnancy. Eighty-five (98.8 per cent) of the pregnancies terminated in nonsyphilitic children. There was one (1.2 per cent) syphilitic infant. The remaining twenty-six patients were women who had relapsed or were reinfected. There were no cases of congenital syphilis in this group. All of the syphilitic infants were born to mothers who had, at the time of delivery, a Kahn titer of 8 or more units or a Wassermann titer of 11 or higher. Their belief that the maternal serologic titer at the time of delivery influences the end results is in opposition to that of the majority of workers.

Frazier[2] treated sixty-one syphilitic pregnancies

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with 2,400,000 units of sodium penicillin. Syphilis developed in only one infant, making a failure rate of 1.6 per cent. A report[8] from the Rapid Treatment Center, Gallinger Municipal Hospital, Washington, D. C., deals with 147 pregnant syphilitic women who were treated with three types of intensive antisyphilitic therapy. The three schedules were: (1) arsenotherapy and bismuth, (2) penicillin therapy only, (3) combination therapy—penicillin, arsenic and bismuth. Eleven of the pregnancies terminated in abortions or stillbirth. There were 128 live births. Only one infant was found to be infected. Eighteen infants were born with a positive cord serologic test for syphilis, but all became negative within one month. The one known infected infant had a negative cord test at birth, attesting to the now accepted fact that the serological tests on cord blood are unreliable for the diagnosis of congenital syphilis.

The results of the University of Pennsylvania[5] and Johns Hopkins Hospital[3] studies in the treatment of the pregnant women with syphilis have demonstrated that penicillin alone has an enormous superiority over any other method of treatment, both as to toxicity and the likelihood of a live nonsyphilitic baby. The report of Ingraham and his associates[5] deals with forty-nine pregnant women. Twenty-six had early syphilis, nineteen early latent, three late latent and one congenital syphilis. Penicillin alone in a total dosage of 1,200,000 or 2,400,000 units was used. Out of the thirty-seven that had gone to term, only one syphilitic infant had been born. The mother of this infant had been given 1,200,000 units of penicillin for secondary syphilis during the fifth month of pregnancy. Clinical relapse occurred during the last month of pregnancy and darkfield positive lesions were present at the time of delivery. It seems probable that the initial use of a larger amount of penicillin or retreatment during the last month of pregnancy would have prevented congenital syphilis in this case.

In the opinion of these workers,[5] the possibility of abortion seemed a definite threat to some pregnant syphilitic women treated with penicillin. Moreover, they believe that it can be avoided by reduction of the dose of penicillin during the first forty-eight hours of treatment, rest in bed, sedation and temporary cessation of penicillin therapy, if signs of threatened abortion are noted. The reaction was interpreted as therapeutic shock.

TABLE I. SYPHILITIC PREGNANT WOMEN TREATED WITH PENICILLIN—STAGE OF DISEASE
From Ingraham et al., J. Ven. Dis. Inform., (Aug.) 1947

Type of Penicillin	No. of Patients	Stage of Disease		
		Early Sympto-matic	Early Latent	Late
Aqueous sodium.....	92	44	36	12
Oil-beeswax.....	46	16	24	6

If this is true, one would expect a higher incidence of reactions in patients with early syphilis than in those with infections of long duration. Such has not been the case. This observation, as pointed out by Goodwin and Moore,[3] tends to weaken the argument that the actual or threatened abortions were due to penicillin-induced Herxheimer reactions.

Leavitt[6] observed two actual and six threatened abortions among twenty-one pregnant syphilitic women treated with penicillin. The stage of syphilis is not stated. Seven of the eight patients who had reactions were treated with the same lot of penicillin. This suggested to him that some impurity in penicillin might exert a stimulating effect on the uterus. It was pointed out that ergot, a powerful oxytocic drug, is the product of a mold.

Goodwin and Moore,[3] however, do not share the opinion that abortion, actual or threatened, is evidence of therapeutic shock in penicillin-treated women. Indeed, the treatment of pregnant women with penicillin has been so successful in their hands that they recommend that all other therapy be abandoned. The incidence of abortion in 290 patients reported by various workers and summarized by Moore,[7] was no greater that that of the population at large.

There is, then, no satisfactory evidence that actual or threatened abortion is more frequent during penicillin treatment of the mother than during other forms of antisyphilitic therapy, or more frequent than the expected incidence of spontaneous abortion in nonsyphilitic women. Speiser and Thomas[9] were unable to find any evidence of unusual effects of penicillin in the uterus of 156 women with early syphilis. The incidence of actual or threatened abortion was 3.9 per cent. In addition, they studied the menstrual cycle of 100 women under penicillin treatment for early syphilis, and in only one instance was there any alteration from the usual cycle.

In a more recent report, Ingraham and his associates,[4] have increased the number of syphilitic

TABLE II. SYPHILITIC PREGNANT WOMEN TREATED WITH PENICILLIN—DURATION OF PREGNANCY WHEN TREATMENT WAS STARTED

From Ingraham et al., J. Ven. Dis. Inform., (Aug.) 1947

Type of Penicillin	No. of Patients	Week in Pregnancy when Treatment was Started			
		1-15	16-23	24-31	32-40
Aqueous sodium.....	92	11	26	34	21
Oil-beeswax.....	46	3	11	15	17

TABLE III. ANALYSIS OF UNSATISFACTORY OUTCOME IN SYPHILITIC MOTHERS TREATED WITH PENICILLIN DURING PREGNANCY

From Ingraham et al., J. Ven. Dis. Inform., (Aug.) 1947

Type of Penicillin given to Mothers	No. of Infants Delivered	No. of Living Infants	Unsatisfactory Outcome				
			Miscarriage	Still birth	Neonatal death	Living Infants syphilitic	Failure Rate
Aq. sodium.	94	89	3	1	1	2	2.2%
Oil-beeswax.	48	41	0	4	3	2	4.9%

TABLE IV. RESPONSE OF THE SYPHILITIC MOTHER FOLLOWING PENICILLIN THERAPY DURING PREGNANCY. ANALYZED ACCORDING TO STAGE OF DISEASE

From Ingraham et al., J. Ven. Dis. Inform., (Aug.) 1947

Type of Penicillin	No. Followed	Serologic Response of Mothers by Diagnostic Groups—Seronegative at End of Observation (6-24 mo.)		
		Early Symptomatic	Early Latent	Late
Aqueous sodium....	92	30 (68.2%)	10 (27.8%)	0
Oil-beeswax.....	45	5 (31.3%)	6 (26.1%)	1 (16.6%)

TABLE V. RESPONSE OF THE SYPHILITIC MOTHER FOLLOWING PENICILLIN THERAPY DURING PREGNANCY

From Ingraham et al., J. Ven. Dis. Inform., (Aug.) 1947

Type of Penicillin	No. Followed	Clinical Relapse	Reinfections	Serologic Response of Mothers at Time of Delivery	
				Seropositive	Seronegative
Aqueous sodium....	92	5	2	66 (71.7%)	26 (28.3%)
Oil-beeswax.....	45	2	0	41 (91.1%)	4 (8.9%)

mothers treated with aqueous penicillin to ninety-four (Tables I and II). In this group there have been two syphilitic infants among eighty-nine living infants, or 97.8 per cent uninfected children from syphilitic mothers. The outcome was unsatisfactory in 5.4 per cent there being three miscarriages, one stillbirth and one neonatal death (Table III). The occurrence of seroresistance following penicillin therapy was high. In an average duration of follow-up of 15.7 months, 32 per cent of the women with early syphilis, 72 per cent with early latent syphilis and all (twelve) of the women with late syphilis failed to become seronegative (Table IV). Retreatment of ten of the patients produced change in the sustained high serologic titer in only two instances. Some patients who were not retreated did not revert to negativity until the second and even third year after treatment. This indicates that a seronegative mother is not essential for obtaining a nonsyphilitic infant. Irrespective of the serological response of the mother, 97.8 per cent of the infants were not infected (Table V).

From this brief review of the literature, it becomes evident that the administration of penicillin alone is the method which most nearly meets the specifications for ideal syphilotherapy in pregnancy. It is a drug with a high spirocheticidal index, of low toxicity, requires a short time to administer and achieves a high incidence of satisfactory results in the mother and a lower percentage of syphilitic offspring than any other drug or method of treatment that we know. Combining all available information, the failure rate after penicillin therapy is approximately 2 per cent.[7] Certainly some, if not all of these failures might have been prevented by a greater amount of penicillin in the initial course or by appropriate retreatment of the mother. This means close observation of the mother throughout pregnancy. Furthermore, the results with penicillin therapy are equally good regardless of the duration of the pregnancy. This contrasts with a failure rate of 5 to 50 per cent from routine chemotherapy, the results depending upon the time in pregnancy treatment is started and the amount administered. The only method of treatment which even closely equals the achievements of penicillin is massive arsenotherapy, and with this method approximately 15 per cent of the infants have been born with syphilis,[7] and the incidence of severe toxic reactions is high (Fig. 2).

The question now arises as to what is the optimum method for use of penicillin in treating the syphilitic mother? Although definitive information is not available, certain plans can be recommended. If water-soluble penicillin is used, the total amount given should be not less than 2,400,000 units and, until more information is obtained, the wise procedure is to give 3,600,000 units. The total duration of treatment should be not less than seven days and preferably should be

ten days. The drug should be administered intramuscularly in saline or aqueous solution at intervals of not less than two or more than three hours. It must be given day and night as one continuous course. A convenient schedule would be a total dosage of 3,600,000 units given as 40,000 units every three hours. This requires ninety injections and covers a period of slightly more than eleven days.

Everything that has been said refers to the use of an aqueous or saline solution of penicillin. The use of oral penicillin in the treatment of syphilis complicated by pregnancy, or in any type of syphilis, can be covered in one sentence. The blood levels obtained are so unpredictable that oral penicillin must not be used for treating syphilis.

Ingraham and his associates,[4] have treated forty-six syphilitic pregnant women with penicillin —peanut-oil—beeswax and compared the results with those obtained from aqueous sodium penicillin (Tables I - V). "A total dosage of 4.8 million Oxford units of amorphous calcium penicillin in peanut-oil-beeswax was given over a period of nine days as follows: a single injection of 150,000 units the first day, of 450,000 units the second day, and of 600,000 units for the succeeding seven days. The injection was given intramuscularly in the buttocks at 4:00 p.m. No other treatment was used." Although the follow-up period is much too short for definitive conclusions, the over-all results are approximately equivalent to those of aqueous penicillin. The failure rate was 4.9 per cent. However, the results suggest that penicillin in peanut-oil-beeswax is less effective for early symptomatic syphilis in late pregnancy, if the fetus is already infected.

When the delayed-absorption penicillin is used, it is necessary to give a total dose approximately twice as great as one uses for aqueous penicillin. The injections must be given every day as one continuous course and, in order to prevent the drug from being absorbed too rapidly, it should be administered in the late afternoon. Muscular activity increases the rate of absorption. Thus, it is best to give the drug after the patient has completed most of the day's work. To date, penicillin in peanut-oil-beeswax in adequate amount has proven approximately as effective in early and latent syphilis as soluble penicillin, and one would expect this to be true of syphilis complicated by pregnancy. However, there is not enough evidence at present to permit a definite conclusion concerning the use of delayed-absorption penicillin in syphilis in pregnancy. If this type of penicillin is used, it is recommended that the patient be given 600,000 units daily for ten days, making a total dose of 6,000.000 units. I am not convinced that it is necessary to start with a low dose.

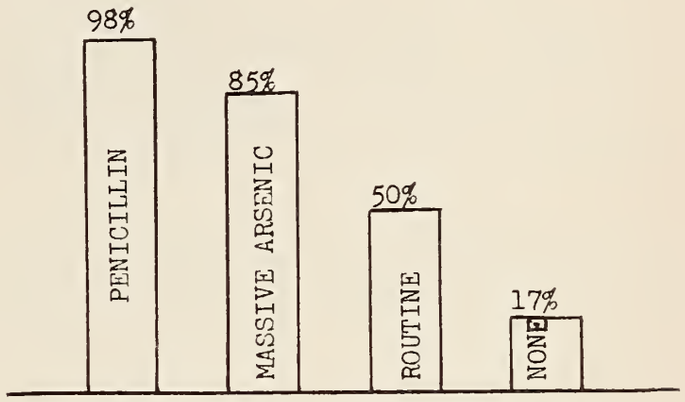


Fig. 2. Satisfactory results (average) obtained by treating syphilitic mothers during pregnancy. Analyzed according to methods of treatment.

Whatever the method of treatment used, the post-treatment observation of the mother is most important. She must be followed clinically and with quantitative blood serologies at least once a month until delivery. During the last three months of pregnancy the examinations should be at two week intervals. The oral mucous membranes, the genitalia and the skin must be carefully searched for evidence of relapse. Retreatment with penicillin should be given if the mother shows evidence of clinical or serological relapse or if the original titer does not significantly decline within three months after treatment. The amount of penicillin in the retreatment schedule should be twice that given in the first course of treatment.

After delivery the mother should be examined at appropriate intervals depending upon the stage of syphilis and the response to treatment. In general, it is wise to delay diagnostic lumbar puncture until after delivery. It can be done conveniently while the mother is confined to bed following delivery. The examination must be carried out in all cases.

The observation of the infant is likewise of utmost importance (Table VI). The child must be followed at monthly intervals for at least six months after birth. Examination must include a careful physical inspection and quantitative sero-

TABLE VI. FOLLOW-UP OF NON-SYPHILITIC INFANTS BORN TO SYPHILITIC MOTHERS WHO WERE GIVEN PENICILLIN THERAPY DURING PREGNANCY

From Ingraham et al., J. Ven. Dis. Inform., (Aug.) 1947

Type of Penicillin given to Mothers	No. of Infants Deliv-ered	No. of Living Infants	Follow-up of Non-Syphilitic Infants	
			Sero-positive at Birth	Ave. Period to Negativity in Days
Aq. sodium.....	94	89	33 (44.6%)	45
Oil-beeswax.....	48	41	17 (45.9%)	51

logic test for syphilis. Roentgenograms of the long bones are desirable. Details of the diagnosis and treatment of congenital syphilis are not within the realm of this paper.

The problem of retreatment of the mother during each succeeding pregnancy cannot be definitely settled. However, it is not advisable to arbitrarily retreat during each pregnancy. If the patient has delivered a nonsyphilitic child, following an adequate course of penicillin, and her subsequent clinical and serological course has been satisfactory, retreatment during ensuing pregnancies is not necessary. All of the available evidence supports this opinion, although the quantity is not great. Ten women in Moore's group[7] and nine in another[7] have delivered normal children in a second pregnancy during which no treatment was given. Speiser and his associates[10] followed eighty-six pregnancies in eighty-four mothers who were treated prior to pregnancy. Eighty-five of the pregnancies terminated in nonsyphilitic children. There was one syphilitic child. While routine retreatment is not necessary, retreatment with penicillin should be instituted if the serologic test remains positive. It is obvious that serological or clinical relapse call for immediate retreatment.

One may rarely encounter a patient who is unable to tolerate penicillin. In such a case, massive arsenotherapy given by a physician with experience in the use of the method would be the treatment of choice.

Summary

1. Penicillin is incomparably superior to all other known antiluetic drugs in the prevention of prenatal syphilis. With penicillin the results are equally good no matter what the duration of pregnancy at the time of treatment.

2. A total dose of 3,600,000 units of soluble penicillin is recommended. This can be given as 40,000 units every three hours for ninety doses.

3. Preliminary studies indicate that penicillin in peanut-oil-beeswax may be an adequate substitute for aqueous penicillin. If this preparation is used, it is suggested that the mother receive 600,000 units daily for ten days.

4. Adequate serological and clinical follow-up of the mother and child is imperative.

5. Routine retreatment during ensuing pregnancies of the mothers previously treated with adequate amounts of penicillin is not recommended, if the maternal serology becomes negative and remains negative. The indications for retreatment during the initial as well as any subsequent pregnancy is discussed.

6. There is no satisfactory evidence that actual or threatened abortions are induced by penicillin treatment of syphilis.

7. Massive arsenotherapy is the treatment of choice in patients who are unable to tolerate penicillin.

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SYPHILIS, MARRIAGE AND THE PUBLIC HEALTH

(Continued from Page 1105)

seventy contacts for each 100 admissions of untreated early syphilis and sixty-one contacts for each 100 admissions of gonorrhea. During the same period the number of contacts reported by private physicians was so small as to be insignificant. It can be seen that very little epidemiologic information is obtained from private physicians. The future of venereal disease control in Michigan is in the hands of the practicing physician.

Neurosyphilis

A Comparison of Treatment Plans Using Penicillin and a Combination of Penicillin and Malaria

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SINCE 1944 there has been a gradual accumulation of data concerning the effectiveness of penicillin in the treatment of neurosyphilis. A report of 118 patients treated in this hospital and observed for a minimum of one year, subsequent to treatment, has been made.[3] The present study includes this series of 118 patients who now have been observed for two years subsequent to therapy, and also introduces a new one-year group. This analysis of a large number of patients and longer period of observation makes it obvious that the conclusions based on the previous study must be revised.

Our first report reviewed the early literature from the first use of penicillin in neurosyphilis by Stokes and associates[7] and consequently will not be repeated. Since then several studies have added to our constantly growing knowledge of the value of penicillin alone and in combination with various other therapeutic agents in the treatment of central nervous system syphilis.

In a three-year progress report from the series under study at the University of Pennsylvania, Beerman[1] has noted that penicillin alone is equal to malaria therapy for paresis, and superior to therapeutic malaria for cases of tabo-paresis, tabes dorsalis, meningovascular syphilis and asymptomatic neurosyphilis. O'Leary and Kierland,[5] conversely, believe that the parenchymatous forms of neurosyphilis are resistant to penicillin therapy and that the "results from the treatment of neurosyphilis with penicillin are still unpredictable and somewhat erratic." Heyman[4] has reported his series of 141 patients with neurosyphilis treated with penicillin (varying amounts from 1,200,000 units to 5,000,000 units) and followed for six to nineteen months. It is his belief that 4,000,000 units is the minimum satisfactory dosage for the treatment of neurosyphilis. The relapse rate with this dosage was approximately 15 per cent, and most occurred within six months after therapy. When forty-eight patients treated with 4,000,000 units of penicillin were compared with a similar number previously treated with fever the response to both types of therapy appeared similar, but symptomatic improvement seemed better with fever. He believes that penicillin does not replace fever therapy as the treatment of choice in late symptomatic neurosyphilis.

Penicillin alone has likewise proven to be an effective therapeutic agent in congenital neurosyphilis,[6,9] Calloway and his associates[2] have reported definite improvement in two cases of syphilitic arachnoiditis with subarachnoid block following 4,000,000 units of penicillin. This is in contrast to the unfavorable results obtained in the past from other forms of treatment. Erb's spastic paraplegia, on the other hand, appears to be as resistant to penicillin as it is to all other known forms of therapy.[8]

Material

Since 1944, a total of 539 patients with various types of neurosyphilis have been treated at the University Hospital. Four hundred and eight of these were treated at least one year ago. We have been unable to check 145 of the patients, and eight have died (none from syphilis). The remainder were treated less than one year ago or were removed for statistical reasons (inactive spinal fluid, ill advised retreatment). This report, then, is of 223 patients treated for some type of neurosyphilis who have been observed for a minimum of one year subsequent to treatment. One hundred and four of these 223 patients have been followed for at least two years since the termination of treatment.

The distribution of the types of neurosyphilis is shown in Table I. In spite of an almost equal number of patients treated by the two methods, the two groups are not entirely suitable for statistical comparison. As was the case in the earlier report, there was a tendency to give fever therapy and penicillin to the most advanced and deteriorated cases. The desire to do the most good for the patient is always present, and consequently, all available forms of therapy were utilized for those who were in the greatest need of help. However, as the effectiveness of penicillin alone became apparent, we have treated more patients by this

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TABLE I. TYPES OF CENTRAL NERVOUS SYSTEM SYPHILIS TREATED WITH PENICILLIN AND MALARIA AND PENICILLIN.

NEUROSYPHILIS	ONE YEAR GROUP			TWO YEAR GROUP		
	CASES	TREATMENT		CASES	TREATMENT	
		PENICILLIN	PENICILLIN & MALARIA		PENICILLIN	PENICILLIN & MALARIA
TYPE	NO.	NO.	NO.	NO.	NO.	NO.
ASYMPTOMATIC	26	19	7	8	6	2
MENINGOVASCULAR	20	12	8	15	9	6
TABES DORSALIS	63	37	26	25	19	6
TABO-PARESIS	43	17	26	21	8	13
PARESIS	71	23	48	35	13	22
TOTALS	223	108	115	104	55	49

TABLE II. RESULTS OF TREATMENT OF 223 PATIENTS HAVING SEVERAL TYPES OF NEUROSYPHILIS. TREATED WITH PENICILLIN AND MALARIA PLUS PENICILLIN, AND FOLLOWED FOR ONE YEAR.

APPRAISAL	TREATMENT	IMPROVED		UNCHANGED		WORSE		TOTAL NUMBER
		NO.	%	NO.	%	NO.	%	
CLINICAL (ASYMPTOMATIC OMITTED)	PENICILLIN	70	79	17	19	2	2	89
	PENICILLIN & MALARIA	73	69	25	24	8	7	106
SPINAL FLUID	PENICILLIN	89	82	16x	15	3	3	108
	PENICILLIN & MALARIA	102	89	11+	9	2	2	115

x INCLUDES 6 PATIENTS WITH NEGATIVE SPINAL FLUID BEFORE TREATMENT
+ INCLUDES 1 PATIENT WITH NEGATIVE SPINAL FLUID BEFORE TREATMENT

TABLE III. RESULTS OF TREATMENT OF 104 PATIENTS HAVING SEVERAL TYPES OF NEUROSYPHILIS. TREATED WITH PENICILLIN AND MALARIA PLUS PENICILLIN, AND FOLLOWED FOR TWO YEARS.

APPRAISAL	TREATMENT	IMPROVED		UNCHANGED		WORSE		TOTAL NUMBER
		NO.	%	NO.	%	NO.	%	
CLINICAL (ASYMPTOMATIC OMITTED)	PENICILLIN	42	86	6	12	11	2	49
	PENICILLIN & MALARIA	31	66	11	23	5	11	47
SPINAL FLUID	PENICILLIN	47	85	8x	15	0	0	55
	PENICILLIN & MALARIA	48	98	1+	2	0	0	49

x INCLUDES 4 PATIENTS WITH NEGATIVE SPINAL FLUID BEFORE TREATMENT
+ THIS PATIENT HAD NEGATIVE SPINAL FLUID BEFORE TREATMENT

method. The two groups are now more nearly equal in severity and rapidity of progression than they were when the first follow-up study was made.

Results

The results of treatment have been gratifying. Tables II and III illustrate the over-all results.

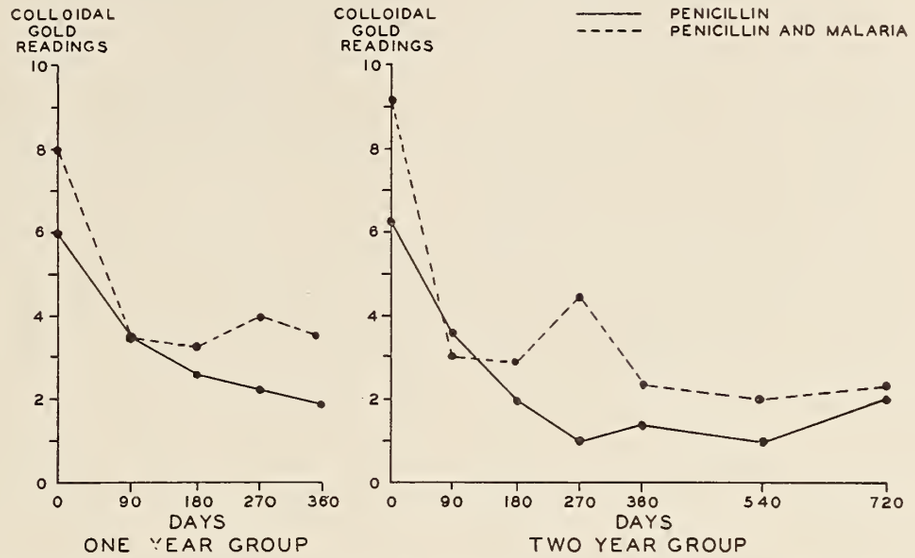


Fig. 1. Totals of first three figures in the colloidal gold test. Entire group was followed for one and two years.

AVERAGE SPINAL FLUID CELL COUNT—ENTIRE GROUP FOLLOWED FOR ONE AND TWO YEARS

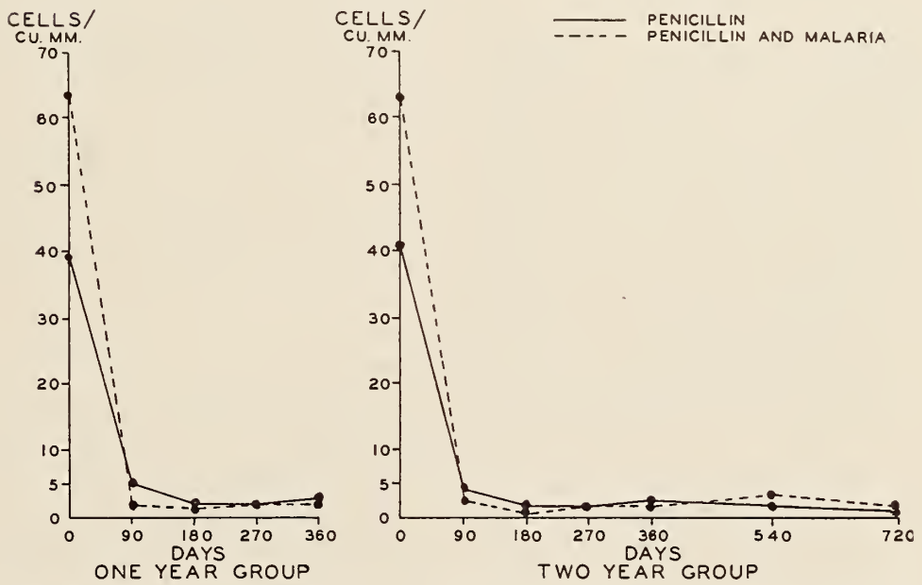


Fig. 2. Average spinal fluid cell count. Entire group was followed for one and two years.

Methods of Treatment

All of the patients received either penicillin alone or penicillin plus malaria (Table I). The penicillin was given in saline, 40,000 units intramuscularly every three hours for 100 dóses, making a total dosage of 4,000,000 units. It was given either alone or in conjunction with therapeutic malaria (tertian), the patient receiving fifty or more hours of fever over 103.5° F. rectally.

The response of the several spinal fluid components is shown in Figures 1-4.

At the end of one year of observation, 79 per cent of the penicillin-alone group showed clinical improvement, and 82 per cent had improvement in the spinal fluid formulas. Those who received penicillin plus malaria attained 69 per cent improvement in the clinical findings, and 89 per cent showed improvement of the spinal fluid abnor-

malities. At one time[3] it was our opinion that those patients who failed to improve during the first year following treatment were in greater danger of deterioration than those who did improve. Actually those patients have not shown deterioration during the second year of observation. Of the 104 patients followed for two years subsequent to treatment, 86 per cent of the penicillin alone group showed clinical improvement and 85 per cent had attained improvement of the spinal fluid abnormalities, with 66 per cent and 98 per cent, respectively, in the group who received combined therapy. No patient has shown progression of the spinal fluid abnormalities during the second year. The few who have relapsed did so during the first year and have been retreated.

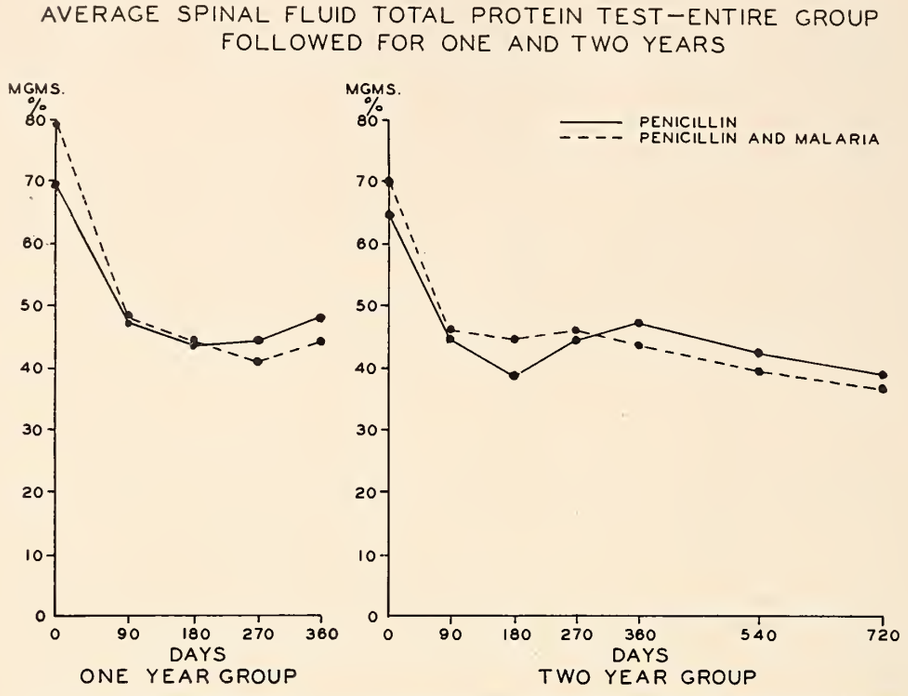


Fig. 3. Average spinal fluid total protein test. Entire group was followed for one and two years.

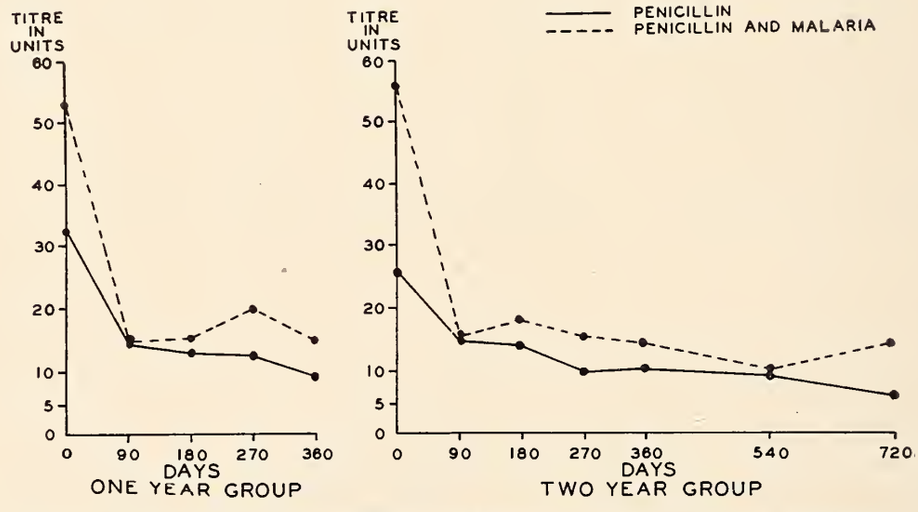


Fig. 4. Average spinal fluid quantitative Kahn test. Entire group was followed for one and two years.

Negativity of the spinal fluid is hoped for in all cases. At the end of one year of observation there were twenty-two patients (21.5 per cent) with negative spinal fluid examinations who had received penicillin alone and 14 (12.3 per cent) in the group who received combined therapy. During the second year of observation seven spinal fluid examinations in the penicillin alone group became negative. In the combined group three reverted to negativity. Thus, after two years of observation,

subsequent to treatment, nineteen (37.2 per cent) of the patients who received penicillin alone and seven (14.5 per cent) who received combined therapy had negative spinal fluid examinations. Only patients who had positive spinal fluid examinations prior to treatment are included in these figures. There is no doubt that the severity of the disease and the degree of deterioration, associated with the more highly positive spinal formulae, accounts for much of these differences in the response of the spinal fluid abnormalities.

With few exceptions, clinical remission has been accompanied by coincident improvement of the spinal fluid. In Figures 1-4, improvement in the several components of the spinal fluid is shown. The cell count first reverts to normal, followed by a fall in the total protein. Later, there is a reduction in the colloidal gold curve* and in the number of Kahn units. The curves are so closely parallel that we are unable to determine any significant difference in the response of the various abnormalities to either method of treatment except that improvement seems to be more rapid after malaria plus penicillin, due to the higher average of the spinal fluid components. The difference in degree of activity prior to treatment seems to be offset by the fact that the curve for the combined group remains above that for the penicillin alone group in the instances in which an abnormality continues to exist.

All that has been said about the two groups as a whole continues to be true when the various types of neurosyphilis are studied individually.

Comment

The condition of the cerebrospinal fluid is the best indicator of the adequacy of treatment in cases of neurosyphilis, and the demonstration of an arrest and/or resolution of the process. The clinical result is difficult to appraise because of the frequent inability to accurately evaluate the often slow, varied and insidious "improvement" or "progression" of symptoms. However, at times improvement has been striking; rarely, deterioration has been rapidly progressive.

The group of patients with asymptomatic neurosyphilis permits the most clearly defined opportunity for a comparison of the effects of the two methods of treatment on the spinal fluid abnormalities. These cases require no discussion. It is evident from the results that there is no value in the addition of therapeutic malaria to a course of 4,000,000 units of penicillin. At the end of two years of observation subsequent to therapy, there is improvement in all cases and in no patient has there been a relapse. Penicillin alone is the treatment of choice in asymptomatic neurosyphilis. The same conclusion can be drawn from the results attained in cases of meningovascular neurosyphilis and in tabes dorsalis.

Taking all things into consideration, morbidity and mortality as well as therapeutic effectiveness, penicillin alone is far less dangerous and probably equal in therapeutic effectiveness to the combination of penicillin and malaria in general paresis. There remains some slight evidence that fever therapy plus penicillin is superior to penicillin alone in producing improvement in the spinal fluid abnormalities in cases of general paresis, but we have the impression that a longer period of observation after treatment will show improvement from penicillin alone equal to that from combined therapy.

Routine chemotherapy received prior to penicillin alone or penicillin plus malaria, age and sex of the patient do not seem to be factors which contribute to the number of failures. The chief cause for progression of the disease is in the individual inability to react favorably to penicillin or fever therapy. Neither penicillin nor therapeutic malaria can erase degeneration or replace scar tissue, and this appears to be the basic cause for failure, even though treatment has been adequate. If patients with neurosyphilis can be treated with an adequate amount of penicillin before symptoms develop, the majority will suffer no disability from the disease.

Summary

1. Two hundred and twenty-three cases of neurosyphilis have been reviewed. One hundred and eight received only penicillin, and 115 were given therapeutic malaria plus penicillin. All cases were followed for a minimum of one year subsequent to treatment, and 104 were observed for two years.

2. Patients with asyptomatic neurosyphilis, meningovascular syphilis and tabes dorsalis responded as well to penicillin alone as they did to combined therapy. This is seen in both the clinical and spinal fluid picture.

(Continued on Page 1132)

*These figures are the average of the total of the first three figures in the colloidal gold curve.

The Role of Penicillin in Gonorrhea

By George Sewell, M.D., and
Paul T. Salchow, M.D.

Detroit, Michigan

IT IS A MATTER of concern to note the tendency in professional circles to regard gonorrhea as a minor infection since the advent of penicillin. This is strictly a layman's attitude and one unworthy of those who realize the potentialities of the gonococcus. It should be remembered that complications do occur, and that the gonococcus is capable of suddenly acquiring virulence which may make its control extremely difficult, as shown by the war experience in Italy and Africa. Too often this attitude of carelessness toward the disease is transmitted to the patient, which may account for the paradox of a rising incidence in the face of the most effective treatment ever available.

First, there are several diagnostic problems that deserve consideration:

1. The culture method of detecting gonococci is by far the most accurate in the diagnosis of gonorrhea, as well as testing for cure.[1] This is particularly true in the examination of women and asymptomatic males. It is estimated that smear examination alone will miss 50 per cent of bacteriological diagnoses in women. We have repeatedly examined male contacts to gonorrhea who were completely asymptomatic, but whose culture of prostatic secretion was positive. This so-called "carrier state" is one of the outstanding problems in gonorrhea control. It can be solved by more thorough examination of contacts rather than dismissal after brief inspection of a patient's external genitalia. Studies at the Social Hygiene Clinic of the Detroit Health Department indicate that urine cultures in males after prostatic massage offer the greatest accurracy in the bacteriological diagnosis of gonorrhea.[2] The unavailability of culture media to private physicians remains an obstacle in some areas. We are hoping a reliable mailing service for culture specimens will soon be offered, perhaps on a state level. At the present time, investigations are being made of the effect of variations in the carbon dioxide content of culture media on growth of the gonococcus, and the results may lead to an efficient medium for delayed cultures. This would be a great aid to the practicing physician.

2. It should not be forgotten that clinical and epidemiological diagnosis of gonorrhea is often justifiable. With the advent of penicillin, it would appear more practical in many instances to treat suspected cases than to insist upon prior bacteriological diagnosis. It should always be borne in mind, however, that penicillin for gonorrhea may mask or delay incubating syphilis. Regardless of the basis for the diagnosis of gonorrhea, post-treatment tests of cure should be carried out in every treated case. A word of caution in regard to the clinical diagnosis of gonorrhea in the adult female: Experience with a large number of clinic cases has shown that the symptoms of gonorrhea are unreliable in the adult female. Many cases who pass their tests of cure bacteriologically show the same cervical discharge as before treatment. Just as many cases of gonorrhea are found with negligible or no vaginal discharge as those with profuse discharges.

3. The material for bacteriological examination should be carefully collected. Vaginal smears from adults are useless. The cervix should be exposed, carefully wiped clean, and clear mucoid secretion obtained from just inside the external os. Stripping of the urethra in the female should not be forgotten. Films should always be thinly spread.

4. In female children with vaginitis, specimens are best obtained with a glass female catheter containing a few drops of normal saline. This instrument is more easily introduced into the vagina than is a cotton applicator. Capillary action, controlled by a finger on the open end, will draw material from deep in the vagina.

Treatment

The greatest problem of gonorrhea treatment today is patient co-operation. It is the responsibility of the private physician not only to cure his patient but to prevent his reinfection. This involves treatment of the infected contacts, either by the physician or some other agency. It is hoped that private physicians will accept this responsibility.

From the Social Hygiene Clinic of the Detroit Department of Health, Bruce Douglas, M.D., Commissioner; L. W. Shaffer, M.D., Director.

The schedules of treatment are presented in the accompanying table for comparison.

These cases were observed for a minimum of three weeks, with at least two negative cultures, at the Detroit Health Department's Social Hygiene Clinic. As a result, the following treatment schedules are recommended:

Drug	Total Dose	Schedule	No. Cases Treated	Number Cured	Number Failed	Cure Rate
Sulfathiazole	20 - 40 Gm.	1 Gm. q.i.d.	99	57	42	57%
Sod. Penicillin (Aqueous)	150,000 U.	50,000 U. q 3 H x 3	44	41	3	93%
Sod. Penicillin (Aqueous)	200,000 U	50,000 U. q 3 H x 4	221	214	7	97%
Sod. Penicillin (Aqueous)	300,000 U.	100,000 U. q 3 H x 3	276	272	4	98%
Sod. Penicillin (Aqueous)	200,000 U.	200,000 U. (1 injection)	81	65	16	71%
Pot. Penicillin Crystallin G in oil & beeswax	300,000 U.	300,000 U. (1 injection)	146	139	7	95%

1. Sodium or potassium penicillin G in aqueous solution. Intramuscular injections of 100,000 units each at two- or three-hour intervals for three doses —total 300,000 units.

2. Potassium penicillin G crystallin, in oil and beeswax (Romansky formula). One injection of 300,000 units.

Those failing to respond to one course of treatment will usually respond to a second at doubled dosage, provided, however, that reinfection has been ruled out. In the presence of complications it may seem desirable to combine penicillin with sulfonamides. In such cases we have used sulfathiazole and sulfadiazine, .5 gm. of each, four times a day for five days, with 300,000 units of penicillin given on the first and fifth days. In gonorrheal ophthalmia, local instillations of aqueous solutions of penicillin, 1,000 units per c.c., are advisable in additional to parenteral penicillin.

Oral penicillin in our experience has proven quite successful. In 196 cases of uncomplicated gonorrhea in quarantined adult females, only one apparent failure was encountered. It is important that the penicillin be well buffered and that it be taken on a fasting stomach.

Infants and children not only tolerate high doses of penicillin quite well but appear to require relatively high doses for gonorrhea. In general, we have given 300,000 units to patients over six years of age, and 150,000 to those under six. If gonorrheal vaginitis apparently resists penicillin, as shown by post-treatment positive smears or cultures, sugar fermentation tests should be done, since some other organism may be present.

Criteria of Cure

One may question the need for tests of cure, when upwards of 90 per cent of cures are usual with a single course of penicillin of adequate dosage. There are, however, two good reasons for follow-up examinations: (1) early detection of reinfection, (2) early detection of incubating syphilis. As a minimum, weekly spreads and cultures with clinical examination on each visit, for three weeks is suggested. If the results are favorable, and the serologic tests for syphilis remain negative, a complete examination should be done at two months, three months and six months.

Complications

Sufficient time has not yet elapsed since the introduction of penicillin therapy of gonorrhea to properly estimate the frequency and severity of the complications that heretofore have always accompanied this disease. There is no doubt that, compared with several years ago when all too vigorous local treatments were used, the immediate acute complications in both male and female should be, and are, much less frequently observed. In fact, in those patients where penicillin is given early enough and in sufficient dosage, such acute complications as acute epididymitis, folliculitis, inguinal adenopathy, acute prostatitis, in the male, and Bartholin gland abscess, salpingitis, in the female, are very rare indeed. In such early and sufficiently treated cases the antibiotic has seemed to be of inestimable value by arresting the disease before it has reached the deeper layers of the mucosa affected and before it has spread by direct extension to deeper structures from which all complications arise. This is especially noted in the marked reduction of the number of complications requiring surgical intervention.

Where formerly it was relatively common to encounter buboes that required incision and drainage, infected follicles that ruptured or needed incision, paraphimoses that needed surgical treat-

ment, et cetera, these are relatively rare occurrences in the clinic that uses penicillin as routine first treatment. Epididymitis is now occasionally observed even in a patient treated relatively late, but this painful and disabling complication itself usually responds to penicillin as does the urethritis that has preceded it. Rarely does gonorrheal epididymitis require surgery for its relief in a patient who has been given the advantage of sufficient amounts of penicillin. Formerly acute prostatic abscess, with or without acute retention, was seen frequently enough and was relieved only by either spontaneous rupture into urethra, rectum, perineum, or by the extensive operative procedure of perineal prostatotomy. This complication is not encountered if penicillin is properly and immediately used. In the female patient, similar operative complications formerly observed are likewise not now encountered.

However, considerable time will yet be necessary before a proper estimate of the frequency and severity of late complications can be made. Such complications as urethral stricture in both male and female; arthritis, acute and chronic; bladder neck fibrosis in the male, sterility, impotence, et cetera, are so late in their onset that a true appraisal cannot yet be made. We do know that the percentage of discharge-free carriers is higher in patients who are so rapidly "cured." We do know that we could formerly keep a patient under observation much longer when clinical signs would diminish more slowly and more gradually. Until a perfect "test of cure" is at hand we must be even more insistent on careful and repeated examinations of all gonorrhea patients for at least six months after cessation of all clinical signs has occurred.

Summary

Gonorrhea remains a potentially serious disease. Treatment on epidemiologic grounds is justifiable in some cases. Adequate doses of penicillin appear to be highly successful and make the treatment of gonorrhea ideal for office practice. Greater effort should be exercised by the physician to follow all "rapidly cured" patients for a period of at least as long as in the pre-penicillin era.

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Chancroid, Lymphogranuloma Venereum and Granuloma Inguinale

Diagnosis and Treatment

By L. W. Shaffer, M.D.

Detroit, Michigan

CHANCROID is a rather common venereal disease, ranking next to gonorrhea and syphilis in prevalence. It is due to the Hemophilus Ducreyi. This is a streptobacillus-like organism which is hard to demonstrate in smears and is cultured with difficulty.

The infection is of world-wide distribution, occurring more frequently in tropical and semi-tropical regions and more commonly in cities than in rural communities. Although the disease is spread almost entirely by sexual contact, its clinical manifestations are more frequent and more severe in men than in women. It is suspected that women commonly act as passive carriers for the infection in the absence of recognizable symptoms of the disease.

The incubation period is short; clinical symptoms usually develop within two to five days after exposure. The lesions in general have the opposite characteristics from those of primary syphilis. The lesions tend to be multiple, are necrotic, painful, rapidly progressive and associated with unilateral buboes which progress to suppuration. Various types are recognized in addition to the typical lesion described above. There is a transient type in which the genital ulcerations are mild and insignificant and heal quickly but are often accompanied by an inguinal adenitis which may readily be confused with lymphogranuloma venereum. There is a hypertrophic type in which the lesions tend to be elevated instead of ragged and undermined, and a miliary follicular type consisting of various small ulcers beginning about a hair follicle. Occasionally the lesions become extremely destructive and are classified as phagedenic. More rarely a serpiginous type of chancroid occurs, characterized by very chronic superficial but extensive ulcerations involving the lower abdomen and buttocks. Finally, since the dis-

ease is autoinoculable, extra-genital lesions have occurred on all parts of the body, especially the mouth and fingers. The possibility of chancroid should be considered more frequently in the differential diagnosis of ulcerative lesions of the skin and mucous membranes.

The diagnosis of chancroid in typical cases does not offer great difficulty. It is quite important, however, that the possibility of mixed infection of chancroid and syphilis be remembered. All cases of chancroid should have darkfield examinations and be followed both clinically and serologically for at least three months before the possibility of such a mixed infection is discarded. In fact, the old axiom that every genital lesion should be suspected of being syphilis until proven otherwise should be kept in mind. The Ducrey test (Ito Reenstierna reaction) consists of the intradermal injection of 0.1 c.c. of a killed suspension of Ducrey bacilli. A positive reaction develops within forty-eight hours and consists of an erythematous papule measuring at least 6 mm. in diameter, surrounded by an erythematous zone which may be considered positive if it measures 15 mm. or more in diameter. The reaction does not become positive until about two to three weeks after the appearance of the lesion. Therefore, the test may be negative if done on a lesion of less than this duration. Unfortunately, once a positive reaction develops it usually remains positive for the rest of the patient's life and a positive reaction simply indicates that the patient has or has had a chancroid infection. A persistent negative test in the presence of a genital lesion of more than three weeks' duration is, however, of great value in eliminating a diagnosis of chancroid. Diagnoses can also be made by means of biopsy, spreads from macerated tissue from cleaned lesions, by cultures or by autoinoculation. However, such diagnostic procedures are not very practicable except in the hands of an expert. Diagnosis, therefore, is usually made on the basis of exclusion and clinical characteristics of the lesion plus a positive Ducrey reaction.

The use of sulfonamides in the treatment of chancroid has offered a great advance over the older, less specific antiseptic methods of local therapy. In general, it is felt that the use of circumcision or dorsal slit as well as the incision of fluctuent buboes is rarely advisable or indicated with present specific methods of therapy. Sulfonamides should be given in dosages of 15 gr. four times daily by mouth. It is desirable to change the type of sulfonamides being used at five-day intervals when it is necessary to continue treatment for more than several weeks or use one of the newer types of mixed sulfonamide tablets. The use of sulfonamides locally as a dusting powder is also of value. Ducrey vaccine by multiple intradermal injections or intravenously in increasing doses is extensively used in European and South American countries, although it has never become popular in the United States. Antimony compounds such as tartar emetic and Fuadin are not specific but are helpful in occasional resistant cases. Penicillin, tyrothricin or streptomycin have not offered any specific effects in the treatment of chancroid, although the first two are valuable in aiding to control secondary infection and the rather frequent complication of fusiform-spirochetosis.

Lymphogranuloma Venereum

This disease is known under several synonyms which increase the tendency to confuse it with granuloma inguinale, namely, lymphopathia venereum, lymphogranulomatosis inguinalis, lymphogranuloma inguinale, namely, lymphopathia ve- remember that lymphogranuloma venereum is primarily lymphatic while granuloma inguinale is a chronic superficial ulcerative process not involving the lymphatics. Lymphogranuloma venereum is a disease primarily of the lymph channels and lymph nodes which lead to chronic bubo formation, genital elephantiasis and ulceration progressing to rectal strictures. It is due to a filterable virus which was first successfully cultured in egg yolk media in 1931. The primary lesion appears after an incubation period of seven to twelve days; lymphadenitis with bubo formation usually follows within ten to thirty days. Studies made of large groups of the population indicate that this disease is much more prevalent than commonly realized. Such studies have indicated, through positive Frei tests, that from 20 to 40 per cent of the adult colored population show evidence of having had the disease.

The symptoms of lymphogranuloma venereum vary markedly between males and females. In the male the disease usually begins with a primary lesion on the penis which is very mild and transient and for this reason commonly overlooked. The first major manifestation is the involvement of the inguinal lymph glands either bilaterally or

unilaterally. More than one gland commonly becomes involved, producing periadenitis, and frequently involvement of the glands occurs both below and above Poupart's ligament. This induration progresses to fluctuation with resulting multiple sinus formation in typical cases. Occasionally a nonspecific type of urethritis develops as a variety of this disease in males. This is known as the Waelsch type of urethritis.

In the female the typical clinical appearance is that of a chronic ulceration involving the posterior fourchette which may be associated with pedunculated smooth globoid tumors attached to this area. The lymphangitis involving the vulva commonly leads to lymphadema or elephantiasis in varying degrees. The lymph drainage from the lower portion of the vulva is to the perirectal glands, which leads to their suppuration with scar formation and rectal stricture. Inguinal adenitis occurs in females in only about one-third of the cases and usually is not severe.

Constitutional symptoms are very common and are an important manifestation of this disease. Arthritis, low-grade chronic febrile reactions, encephalitis, erythema multiforme, erythema induration, et cetera, are recognized complications. This possibility should be given greater consideration in differential diagnosis and the Frei test used more extensively in toxic states of undetermined origin. Extragenital lesions also occur with fair frequency, especially involving the mouth and cervical glands. The possibility of lymphogranuloma venereum should be considered in cases of suppurative cervical adenitis of nontuberculous origin.

The diagnosis of lymphogranuloma venereum should be made on the basis of acceptable clinical findings plus an associated positive Frei reaction. In the original Frei test, human antigen made by diluting the pus from a bubo of a known case of lymphogranuloma venereum was used (1925). Later the virus was transferred by intracerebral inoculation to mice, and mouse brain antigen was used as a source of the virus. At present the virus is grown on embryonic egg yolk and this is used for the test. One-tenth of a cubic centimeter of this killed virus is injected intradermally along with a control to make certain that the patient is not sensitive to egg yolk. The test should not be read before forty-eight hours. A positive test consists of an inflammatory papule measuring at least 7 mm. in diameter. Unfortunately, like the Ducrey test, a positive reaction simply indicates that the patient has or has had lymphogranuloma venereum. Therefore, clinical findings must be compatible with the Frei test to be diagnostic. A complement fixation test on the blood serum can be made using the egg yolk extract as an antigen. This test would be valuable in those cases where the Frei test is of questionable positivity. Unfortunately, such tests are not commonly available. Other clinical confirmatory findings which should be helpful are the presence of an associated hyperproteinemia and hyperglobulinemia. The sedimentation rate is usually increased, and a moderate leukocytosis is present.

The treatment of lymphogranuloma venereum consists in the use of sulfonamides. Treatment needs to be continued for a long period of time, and as stated under chancroid, it is felt that the type of sulfonamide used should be changed frequently or a tablet containing mixed sulfonamides used. The dosage recommended is at least 15 gr. four times daily. This can be kept up for several weeks, followed by a week's rest, and repeated for several months if no toxic manifestations from such therapy develop. Although sulfonamide therapy is quite effective in early cases, late cases with much scarring respond poorly if at all. In fact, with advanced rectal stricture the healing of the inflammation under sulfonamide therapy frequently increases the contraction and symptoms of the stricture. Vaccinotherapy using the egg yolk antigen is of value and can be utilized by both intracutaneous, subcutaneous and intravenous injection. Its use has never been popular in this country. Convalescent blood serum probably offers some aid but is difficult to secure and rarely used. In advanced cases, particularly with rectal stricture, surgery may be necessary if dilatation of the stricture cannot be satisfactorily carried out.

Granuloma Inguinale

Granuloma inguinale is a chronic granulomatous and ulcerative process commonly involving the inguinal region and genitalia. Although it is classified as a venereal disease, its means of transmission has not been definitely proven. It has been suggested that the pubic louse may act as a vector. It is due to Gram-negative encapsulated organisms (Klebsiella granulomatis) called Donovan bodies, commonly found in large macrophages from the involved tissue. These bodies have re-

cently been cultured in the embryonic egg yolk of the chick. They can be demonstrated in the involved tissue through stained scrapings or biopsies. The incubation period is quite variable and is commonly placed between eight days and twelve weeks.

There are three main types of granuloma inguinale. The most common is the vegetative type which begins as a small papule and increases in size. The surface epithelium becomes eroded, leaving a red granular base. The lesion increases in size and produces a sclerosing granulomatous ulceration. The beginning lesions usually occur on the glans or inner surface of the prepuce in males, or the vulva, vagina and occasionally the cervix in females. The amount of pain is surprisingly slight even in late cases where extensive ulceration is present. The ulcerative process remains superficial and tends to extend in a linear distribution along the inguinal region, spreading by continuity or by discrete daughter-lesions in the immediate neighborhood. The border of the ulceration is sharply defined, usually elevated, and the central area consists of beefy red, pebbly granulation tissue. A second ulcerative type is more uncommon. It begins as a vegetating type, becomes secondarily infected leading to ulceration and a foul-smelling exudate. A third chronic cicatricial type results in extensive keloidal-like scarring in which islands of active granulomatous tissue remain.

Although the disease is called granuloma inguinale, it is not limited to this area. The glans, prepuce and shaft of the penis are frequently involved in males; the labia, clitoris, vaginal orifice and occasionally the cervix in females. The process may extend from the typical inguinal involvement to the perineal and anal region. Occasionally elephantiasis may also be present. Extragenital lesions, although they may occur about the mouth, lips, nose and throat, are nearly always secondary to genital involvement.

A diagnosis of lymphogranuloma venereum can be made with fair accuracy in typical cases on clinical grounds alone. The diagnosis, however, should always be confirmed by the demonstration of Donovan bodies in scrapings or biopsies. Tuberculosis, giant and serpiginous chancroid, late cutaneous syphilis and carcinoma may need elimination in differential diagnosis. In securing spreads, the lesions should be thoroughly cleansed and clean granulation tissue removed by scraping with a sharp curette. This tissue should be crushed and spread between glass slides, dried and stained with Wright's or Gimesa's stain. If Donovan bodies are not demonstrated, a biopsy should be carried out. They can usually be readily demonstrated in paraffin sections stained with hemotoxylin and eosin. Specimens should be taken by preference from the margin of the lesion or where the granulomatous tissue is clean and most active. It is probable that a specific intradermal antigen made from capsular substance secured from cultures in egg yolk of the developing chick embryo will be available in the near future for a specific intradermal test, as well as a specific antigen for a complement fixation test on the patient's blood serum.

The treatment of granuloma inguinale has been revolutionized with the recognition of the highly specific effects of streptomycin. Lesions heal with spectacular rapidity under this treatment, and it is expected that permanent cures will result in the majority of cases. However, since relapse was such a frequent feature of the older antimony treatment, only prolonged further observation will determine whether relapse may also occur with streptomycin. At present the recommended dosage of streptomycin is 4 gm. daily given 0.5 gm. every three hours around the clock, and this continued for five days. This means a total of 20 gm. of streptomycin administered in five days. The possibility of toxic reactions will justify close observation of these cases, but to date no serious reactions in the kidneys or eighth nerve have been reported. A less intensive treatment schedule is being employed in the Intensive Treatment Center of the Detroit Health Department consisting of 3 gm. daily for three days, 2 gm. daily for 3 days, and 1 gm. daily for five days. This calls for a total of 20 gm. of streptomycin in eleven days.

Prior to the introduction of streptomycin, antimony was the treatment of choice and was fairly specific. This was usually given in the form of tartar emetic, Fuadin (Winthrop), Anthiomoline (Merck), or Diramin (P. D. & Co.). The effectiveness of these drugs decreased in proportion to the chronicity of the disease. In general, using Fuadin as an example, it was recommended that 3 to 5 c.c. should be given intramuscularly three times per week until healing was well established, then twice a week until healing was complete, and finally, that it should be continued

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Editorial

TISSUE IMMUNITY STUDIES BY REUBEN L. KAHN

SOME EIGHTEEN years ago Dr. Kahn became interested in a research field aside from serology, namely, that of the defensive role of the tissues in immunity, particularly their localizing capacity for infectious micro-organisms. This localizing capacity prevents the micro-organisms from entering the blood stream and becoming widespread throughout the body; hence, it is of great importance to the life of an infected host.

Dr. Kahn has written some thirty articles on the role of the tissues in immunity and a book of more than 700 pages on *Tissue Immunity* (Springfield and Baltimore: Charles C Thomas, 1936). Because of the extensive nature of these studies, some workers in the scientific world associate Doctor Kahn's name only with such studies and not with serology. In the summer of 1947, during the International Microbiological Congress in Copenhagen, he was discussing some aspects of tissue immunity with a professor of bacteriology who had written a book in which Dr. Kahn's tissue immunity studies were widely quoted. In the course of their conversation the professor remarked, "I suppose you realize that you have a famous name. Perhaps you are related to Dr. Kahn of the Kahn reaction."

Dr. Kahn presented a paper on "Tissue Reactions in Immunity" before the Medical Sciences Section of the American Association for the Advancement of Science at the annual meeting in December, 1933, in Boston. He left Boston the same afternoon because he was scheduled to attend the meetings of the Society of American Bacteriologists in Philadelphia, which were being held at the same time. On returning to Ann Arbor several days later, he learned that he had been awarded the eleventh annual prize of $1,000 by the American Association for the Advancement of Science for the outstanding paper, out of 1,400, read at the Boston meetings. In that paper, he presented a method for measuring the immunologic responses of the different tissues of an immunized animal and showed that the skin possessed a greater immunologic response than any of the other tissues studied. Dr. Kahn recently summarized some aspects of his tissue immunity studies in an article published in the September, 1948, issue of the *Scientific Monthly,* at the request of the editor of that journal. It is these tissue immunity studies, combined with his serologic studies, that have caused him to be drawn into immunologic and serologic studies of cancer.

ELIZABETH B. MCDERMOTT
Serologist, University Hospital
University of Michigan

OUR SOCIAL PROGRAM

LAST MONTH we published General Paul R. Hawley's speech presented before the Conference of Presidents and Other Officers and behind closed doors to the House of Delegates of the American Medical Association. We hope every member has read that article, and that those who have not will immediately take time to do so. There is nothing more important.

Doctor Hawley tells of apathy, of distrust, of fears of each other, and of gross neglect in high places that have lost for the profession the power to determine the conditions under which it shall practice medicine. He says we may possibly regain control by joining efforts with those who are directing future trends and by bending every effort to provide for the people the services which they are demanding, and which they have the right and power to demand.

When the Blue Cross and Blue Shield officials attempted to provide some form of meeting national service coverage, obstacles were erected. We have battled with windmills and to no purpose except to becloud the issue; for example, the A.M.A. Council on Medical Service called a conference in Chicago, June 19, 1948, *"to protest the proposed merger of Blue Cross and Blue Shield."* Dr. Hawley reports that such a plan never was proposed. Such tactics delayed action and by injecting a false bogy diverted attention from the great necessity of planning a service which would meet the national need.

Dr. Hawley gives the medical profession just three years to offer its leadership or accept the dominance of those whom we will not relish. As

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Michigan's Pioneering Scientists

It is with humility that I approach this new year of endeavor into which the Michigan State Medical Society is now entering. I have a full realization that the accomplishments of Michigan Medicine are many, and perhaps some are revolutionary, but also that serious problems still confront us.

The work of Michigan Medicine is outstanding, not only in the field of medical socio-economics, as evidenced by the patterns it has set in medical care for the rest of the country, but also in the scientific achievements of our profession.

We have two great institutions devoted to the education of medical students and practicing physicians. The faculties of both Michigan medical schools are universally recognized for their scientific attainments, but in addition, for their abilities to develop better qualified doctors of medicine. Devotion to medical research has led to many discoveries and developments in medical and surgical techniques. Unselfish zeal in the rapid dissemination of this knowledge to the profession of the state has resulted in the early application of new diagnostic and therapeutic measures to the treatment of patients, thus increasing the standard of medical care.

This number of THE JOURNAL is designated as an anniversary recognition of the Kahn Reaction. Twenty-five years ago Dr. Reuben L. Kahn announced his reliable test for the detection of syphilis which has proven to be of much benefit in the discovery, treatment, and eradication of this dreaded disease. This, an example of the accomplishments of medical research, is a distinct tribute to the high calibre of scientific men of which our state can boast. Their work is a constant incentive to the practicing physicians of Michigan.

Michigan Medicine is proud to salute and honor one of our pioneering researchers—Dr. Reuben L. Kahn.

E. F. Sladek, M.D.

President, Michigan State Medical Society

President's



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OUR SOCIAL PROGRAM

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soon as the nation's money is not needed for defense or armament, it will be diverted to something else and that could be compulsory health service, whether we wish it or not. That is labor's program. He says the question will not be decided by reason, but by emotion.

The medical profession of Michigan saw this social trend many years ago, and has been demanding that medical societies assume leadership in health services. We have proven that medical men can step out in front and make good in these efforts. We pioneered the application of the voluntary, non-profit insurance principle to health service. Michigan Medical Service, our brain child, is leading the way but its program is not yet fully adequate. The time is upon us when more complete coverage must be given, with two or three forms of contract. We can do it. We have now in Michigan over 1,100,000 persons with medical service protection, over one-seventh of the entire nation.

STILL AT WORK

THE URGE to socialize medicine has again produced a program which must be faced by our people. Doctors in positions of responsibility have sensed this social change and have cautioned our members about it repeatedly. Still some members think there is no danger. On Thursday, September 2, 1948, Oscar R. Ewing, Federal Security Administrator, again threw down his challenge to private medical practice and our American way of life. He issued a report growing out of the National Health Assembly in Washington last May (which was held at the direction of President Truman), stating that inability to pay for medical care is killing 325,000 Americans every year and is costing 4,300,000 man-years of work and $27,000,000,000 in national wealth. He claims that more than 800 doctors joined in the preparation of this report after the meeting of medical and lay delegates in Washington last May. We doubt if there are 800 doctors in the United States who are trying to destroy the good work of our profession.

Socialized medicine has been tried in various countries with results which do not bear out the claims of Mr. Ewing, Mr. Truman, Mr. Wagner and the rest. The doctors in England thought their flurry into socialized medicine thirty years ago held no sinister threat. Many of them believed that it was a benefit because of certain services rendered to underpaid working people. But the small foot in the door turned out to be a mammoth one. Now England is completely socialized as far as health services are concerned. Every number of the British Medical Journal contains articles and letters indicating that they are unhappy in their new condition.

The news report of Mr. Ewing's release is on another page. We should all read it and consider: *we are facing just as serious a menace as has swept England.* Only by constant watchfulness, all working together, can we defeat the organized and entrenched forces which are using millions of government money to gain control of health services. We must offer a workable program of our own.

OSCAR EWING'S FIGURES

THE LONG delayed report to the President from the National Health Assembly of last May makes a person gasp when considering the reliability of its figures. A survey was made in every county in the United States by the members of the American Medical Association some years ago to find out if the charge was true that thousands of people were unable to get medical care. The report was NO. We have asked many well-posted people if they know of a single person that had died for lack of medical care, because of inability to pay, or any other reason, and the reply was invariably that the only cause of inability to get medical care is emergency or choice. We doubt the 325,000 statement—it is probably less reliable than the percentages of draft rejections for lack of medical care—PREPOSTEROUS.

How about training 225,000 physicians by 1960? This means turning out 20,455 a year, for just eleven years, for the present school year has already started and cannot be counted. That is three times the number now possible to educate in the medical schools. Can the teaching facilities be tripled immediately? Where is the money to come from? It is estimated that the physical plant to train one doctor costs well over one hundred thousand dollars. A mere twenty billion dollars for immediate investment and a building

program to be completed in less than a year. And what of the teaching faculty? PREPOSTEROUS.

"The nation now spends eight and a half billion dollars for health and medical services." Federal, state and local governments supply about $1,962,000,000 of this, and the balance comes from private sources. Now Mr. Truman and Mr. Ewing would cut off these private sources and increase federal outlays from $743,000,000 to $2,312,000,000 by 1960, and increase state and local contributions from $1,219,000,000 to $1,795,000,000. This all adds up to less than half of what we are now spending by private endeavor. Do the social planners think they can supply the vastly increased services they promise for half the money? Again PREPOSTEROUS.

HOSPITAL FACTS

HOSPITALS are being used much more frequently than in the past and hospital costs are increasing. We mentioned this fact editorially in The Journal for April, 1948, pointing out some inadequacies. A recent analysis from the American Hospital Association Directory gives rather exact figures which bear out statements made in April. Almost eighteen million people were admitted into 6,173 hospitals in the United States in 1947, which means that one person out of every eight received hospital care. This is two million more than for the previous year, 1946. The average cost of caring for a patient for one hospital day in general hospitals rose from $9.39 to $11.09 in this one year. The average income from patients was $9.71 per day, leaving a deficit of $1.38.

Seventy-nine full-time employes are needed for every one hundred patients in all types of hospitals, but in general hospitals 151 employes are used for every one hundred patients to provide the high standards of patient care which is now prevalent. The average patient stayed eight days in 1947, as compared with 9.1 days in 1946. This fact is encouraging because earlier entrance in the hospital assures quicker recovery. However, the overhead charges, operating room, anesthetic, laboratory, pharmacy, et cetera, are divided into 8 parts instead of 9.1 which makes a considerably larger daily cost.

The use of hospitals has doubled in ten years. In 1937 there were 9,221,517 patients admitted. These facts help to account for the increased hospital expense, but do not solve the problem. Representatives of the Michigan Hospital Association met with The Council of the Michigan State Medical Society at our July meeting and expressed grave concern over the future outlook.

Some of the financing problems may lie with hospital management and the prevailing plan of many years of undercharging for ward beds and charging for semi-private beds just enough to cover the expense, allowing the private rooms to carry most of the burden. In these times, with hospitals crowded, many people must use ward beds who should pay the full carrying charge and would occupy semi-private or private rooms if they were obtainable.

But a considerable percentage of the inadequate financing is due to state and local appropriating bodies, legislatures, et cetera, fixing an upper limit which the government will pay for the hospital services to its proteges, of from two to five dollars a day less than the actual cost of hospital operation. We believe that the government has no right to demand services, whether medical, hospital, housing, food or clothing, at a price under the costs of furnishing such services. That, in fact, amounts to involuntary contributions because of underpayment.

PUBLIC INFORMATION

MANY TIMES during the past few years we have invited attention to articles in the lay press and the national magazines telling allegedly the story of public health or picturing the medical profession in an unfavorable light. We have mentioned the apparent inability of the profession to command favorable publicity. The propaganda from the governmental bureaus has been for a distinct purpose, and despite the fact that our own money was being used, the result was too biased even to be sanctioned.

But now we have an opportunity to commend one of the great national magazines for an outstanding job of public information, and one that does hold the medical profession up to a sympathetic view. The *Saturday Evening Post* for October 9, 1948, has an interesting and very well-prepared article on The Country Doctor. Mr. Steven M. Spencer, associate editor of the *Post*, and John L. Bach of the A.M.A. headquarters went to Rotan, Texas, spent several days and came back with a very readable and understanding story. There are distinct advantages and compensations to the country doctor who will devote himself unstintingly to his work, and who will consider and act as if his rural patients were true friends as well as deserving patients.

Reuben L. Kahn, M.S., Sc.D.

A quarter of a century ago, a test for syphilis was developed in the Laboratory of the Michigan Department of Health. This test has long since made its author part of the annals of the State of Michigan and renowned on many continents. It was twenty-five years ago, on October 10, 1923, that Doctor Kahn, then Immunologist at the Michigan Department of Health, made the original presentation and demonstration of his newly developed precipitation test for syphilis, now known as the standard Kahn test, before the Laboratory Section of the 52nd Annual Meeting of the American Public Health Association in Boston. Two years later, on October 15, 1925, at the recommendation of the late Dr. C. C. Young, Director of Laboratories of the Michigan Department of Health, the Kahn test was made standard in those laboratories. On December 30, 1925, the Bureau of Medicine and Surgery of the U. S. Navy announced the establishment of the Kahn test as the standard method in Naval medical laboratories. Since then, the Kahn test came into wide use throughout the medical world, and today it is the most widely used test for syphilis. Furthermore, the principles of precipitation in syphilis which Doctor Kahn brought to light, formed the basis also of other precipitation tests for syphilis.

Doctor Kahn's academic work began in 1907, when at the age of twenty he became a freshman medical student at the then University of Valparaiso Medical School, at Valparaiso, Indiana. Only the first two years of medicine were given at that school. After completing these years, he decided to obtain the bachelor's degree of science, to give himself a better preparation for a career of medical research, before continuing his medical studies. But clinical medicine was never to claim him, for after obtaining his B.S. degree in 1911, he turned to Yale University to learn methods of research in the Department of Physiological Chemistry. When he received the M.S. degree in that University in 1913, he decided to work towards a doctor's degree with a distinguished bacteriologist whom he greatly admired, Dr. William H. Park, of New York. This degree was awarded him in 1916 at New York University.

Doctor Kahn then became research assistant in the Harriman Research Laboratory of New York until World War I, when in 1917 he was commissioned First Lieutenant in the Sanitary Corps of the U. S. Army. After his discharge from the Army in 1919 as Captain, he returned to the Department of Bacteriology of New York University, where he remained until he came to the Michigan Department of Health in January of 1920. It was in the latter Department that Doctor Kahn developed the test for syphilis which bears his name. In 1928, Doctor Kahn came to the University of Michigan as Director of Clinical Laboratories of the University Hospital and Assistant Professor of Bacteriology and Serology in the Medical School. In the same year, he visited a number of European medical centers and participated in a "competitive" serological conference in Copenhagen, Denmark, at the invitation of the League of Nations Health Organization. It was because of the superior results given at that conference by the Kahn test, referred to by the delegates of the conference as the "American test," that this test began to be employed on a world-wide basis.

A side light of the Copenhagen conference was the amazement of the delegates that this American test, so rapid that the results are obtainable in about five minutes after mixing the reagents, could be so reliable. Soon, some cynics among the delegates found the answer. It was the American methods of efficiency applied to medical science.

To Doctor Kahn, his development of the test was not an end, but a beginning of the study of the serology of syphilis through the medium of precipitation. As is evident from his bibliography appended to this article, during these twenty-five years he has been the author of four books and some 170 articles based on data obtained in his laboratory. Three of the books and some 140 of the articles deal with serology. Doctor Kahn's major aims in his serologic studies through these years were to gain an understanding of the nature of serologic reactions in syphilis and to solve the problems of false negatives and false positives. That these studies have proved fruitful is evident from the article in this issue on

"Twenty-five Years of Precipitation Studies in Syphilis (1923-1948). Of the ten Kahn procedures listed in that article, the most extraordinary one is unquestionably the "universal serologic reaction" which promises also to be of clinical value in diseases other than syphilis.



Fig. 1. Dr. H. J. Stafseth of Michigan State College brings his class in bacteriology to Dr. Kahn's laboratory for a lecture and demonstration of the Kahn test, twenty-five years ago.



Fig. 2. Dr. Malcolm H. Soule of the University of Michigan brings his class in bacteriology to Dr. Kahn in the year 1923.

Doctor Kahn was greatly disappointed when he learned that, because of the age limit, he was ineligible to serve in the Army in World War II. Nevertheless, he served by providing consultation in serology to the medical departments of the U. S. Army and U. S. Navy which required routine Kahn tests on all their personnel at least at the time of induction and release from the Armed Forces. Doctor Kahn's laboratory also served the U. S. Public Health Service, especially during the war. At the request of that Service, quantitative Kahn tests were performed at the Serology Laboratory of the University Hospital, on specimens submitted by the numerous Rapid Treatment Centers for venereal diseases, established throughout the country under the Lanham Act for the protection of the Armed Forces.

In his early childhood, Doctor Kahn was brought to the United States by his parents from the vicinity of Kovno, Lithuania. His indebtedness to the country which gave him the opportunity to prepare for a medical research career is very deep. To him, this land is still the great land of opportunity. A strong believer in democracy, he is a warm humanitarian. While associated with the Laboratories of the Michigan Department of Health at Lansing, he would occasionally go to Ann Arbor for week ends, ostensibly to spend some time in the University library. But those close to him knew that what brought him to Ann Arbor, in addition to checking up on late medical journals, was the inspiration of taking walks on the University campus. It is consistent with his nature that Doctor Kahn has always refused to accept any personal profit from the sale of Kahn test reagents or equipment.

If you should have occasion to visit Doctor Kahn in his laboratory, you will find that the door to his office is always open. He feels that members of his staff particularly should have ready access

to him. You are likely also to find in his office or laboratory, students from far and near who have come to spend some time with him.

On visiting Doctor Kahn's laboratory, one cannot help but be impressed by the spirit of enthusiasm which prevails there. If you were to listen to Doctor Kahn explaining the nature of serologic reactions in syphilis, or the possibilities of the universal reaction with lipid antigen in medicine, or some aspects of immunologic studies in cancer, you too would sense that spirit of enthusiasm.

When does Doctor Kahn do his writing of scientific articles? Mainly during week ends when he can "hide" himself and do some quiet thinking. Almost invariably, he brings a folder of written material Monday mornings to his secretary for typing.

At present, Doctor Kahn is Associate Professor of Serology of Syphilis in the Department of Dermatology and Syphilology, University of Michigan Medical School; Chief of Serology Laboratory, University Hospital, Ann Arbor; Special Consultant, U. S. Public Health Service; Consultant in Serology, U. S. Naval Medical School, Washington.

The following is a brief summary of some of the extracurricular activities of Doctor Kahn and of honors conferred upon him:



Fig. 3. Dr. Kahn demonstrating the Kahn reaction to two foreign visitors, a quarter of a century ago.

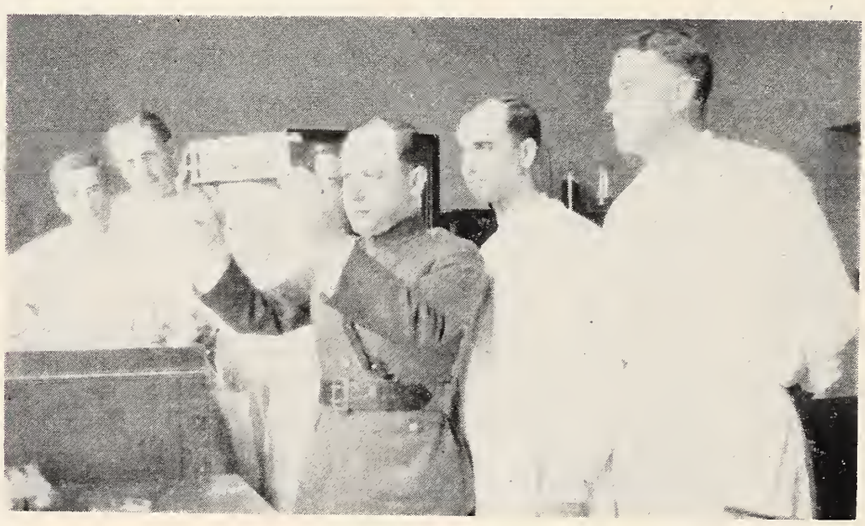


Fig. 4. Dr. Kahn demonstrating the Kahn reaction to United States Army men of World War I.

1. Invited by Health Organization of League of Nations to visit certain European Medical Centers, attend conference on serology in Copenhagen and give lectures to medical groups. Visited Scotland, England, Germany, France, Denmark and Sweden; also, by special invitation of the Russian Government, gave a series of lectures in Moscow and Leningrad. *April to September, 1928.*

2. Invited by Health Organization of League of Nations to visit certain South American countries and attend conference on serology in Montevideo and give lectures. Visited Brazil, Uruguay, Argentine, Chile, Peru and Cuba. *September to December, 1930.*

3. Honored by resolutions of joint session of the Michigan State Legislature "for distinguished medical research . . ." and "for the ideals which have motivated his endeavors and have caused him to accept in satisfaction of his work a knowledge of service to humanity rather than of material reward." *April 14, 1931.*

4. Addressed Immunologic Conference (Volta) in Rome at invitation of Royal Academy of Italy. *October, 1933.*

5. Recipient of the Eleventh Annual Award from the American Association for Advancement of Science, for the "outstanding contribution": Tissue Reactions in Immunity, presented at the annual meetings of the Association in Boston. *December, 1933.*

6. Invited again by Health Organization of League of Nations to come to Europe to attend Serologic Conference. Invitation subsequently cancelled on account of World War II. *September, 1939.*

7. Recipient of honorary LL.D. from Valparaiso University, Valparaiso, Indiana, at Seventieth Annual Commencement. *April, 1944.*

8. Delivered series of lectures in Havana in commemoration of the opening of the National Hygienic Institute, at invitation of Cuban Government; presented with the Order of Carlos J. Finlay. *May, 1944.*

CIRCULAR LETTER.

Serial No. 420-1925.

WASHINGTON, D.C.

DO NOT ADDRESS THE SIGNER OF THIS LETTER BUT ADDRESS YOUR REPLY TO BUREAU OF MEDICINE AND SURGERY NAVY DEPARTMENT, WASHINGTON, D. C. AND REFER TO No.

JEH MET 125561(124).

30 December 1925.

To All Medical Officers.

Subject Kahn Precipitation Teet Established ae Standard.

References (a) Cir Let Serial No Special, Jan. 19, 1924. Nav. Med. Bulletin, May, 1924, p. 638.
(b) Serum Diagnoeie of Syphilie by Precipitation. By R. L. Kahn, Baltimore, 1925.
(c) "....The Kahn Precipitation Test " Houghton, U. S. Naval Medical Bulletin. Nov 1925, p. 347.
(d) Circular Technique of Kahn Precipitation Test.

1 Studies in the eerum diagnosie of eyphilie and yaws having demonstrated the Kahn Precipitation Test to be in respect to technical simplicity particularly euitable for general use in the Navy, and to possess in high degree the requisite specificity and reliability, it is directed that hereafter the Kahn Test be regarded as the standard test, and be routinely so employed Whether or not other tests are employed is optional, but, if employed, they are to be in addition to the Kahn Test, paralleling it and intended chiefly to eerve ae a useful check on technique

2 Reference (b) and unit outfits containing the necessary apparatus will be furniehed all shipe and stations on requisition on the U S Naval Medical Supply Depot, Brooklyn, N. Y. Copies of Reference (d), and standardized antigen ready for use with either serum or spinal fluid, may be procured on written request on the Commanding Officer, U. S Naval Medical School, Washington, D. C.

3 Reference (a) is accordingly cancelled.

A. W. DUNBAR,
Acting.

DEPARTMENTAL DISTRIBUTION X.

Fig. 5. Kahn reaction becomes standard test in the Navy in 1925.

9. At invitation of Anglo-American Caribbean Commission, State Department, Washington, visited the Caribbean area and delivered lectures in Trinidad, Barbados, Puerto Rico, Santa Domingo, Haiti, Jamaica and Panama. *October to December, 1944.*

10. Invited to attend "Primer Congreso Mexicano de Medicina" in Mexico City and present two papers, one on serology and the other on tissue immunity. *August 4-10, 1946.*

Bibliography

This bibliography by Dr. Reuben L. Kahn is published on the occasion of the twenty-fifth anniversary of the Kahn reaction (1923-1948).

Publications by Reuben L. Kahn

Books

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NEUROSYPHILIS

(Continued from Page 1115)

3. The two groups with paresis and tabo-paresis responded as well clinically to penicillin as to malaria and penicillin, but the latter method retains a slight superiority in producing improvement in the spinal fluid findings after two years of observation. We believe that a longer period of post-treatment observation is necessary before any final conclusions can be drawn regarding this group.

4. The response to the combination of malaria and penicillin therapy seems to be more rapid, but all things considered, the long term result from penicillin therapy alone may be just as good. It certainly is less hazardous.

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in congestive heart failure . . .

"Aminophyllin may be given in the form of rectal suppositories (0.25 to 0.5 Gm.) or intravenously (0.24 Gm. in 50 cc. of fluid, 0.48 Gm. in 100 cc. of fluid), both for its diuretic effect and for its bronchodilating action, which relieves dyspnea."[1]

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*Searle Aminophyllin contains at least 80% of anhydrous theophylline.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

NATIONAL VD CHIEF COMMENDS SHOW

The sideshow technique used by the Bureau of Venereal Disease Control in attracting people to their educational movie and exhibit at the county and state fairs has been commended by Theodore Bauer, M.D., Chief of the Venereal Disease Division of the United States Public Health Service.

"This show may set an educational pattern for all the northern states to use in increasing voluntary venereal disease examinations," the national authority told Governor Kim Sigler.

He pointed out that in this area the majority of venereal disease cases occur in farm or industrial workers who are between sixteen and twenty-five years of age and who have less than a tenth-grade education. This group is difficult to reach by ordinary educational methods such as health meetings, pamphlets or health articles.

The midway show with a vociferous barker and with signs reading "The Undiscovered," "Forbidden Facts Revealed," "Frankly Shown," and "For Adults Only" attracted members of this group. Some who saw the show returned to the tent to tell attendants that after seeing the educational motion picture they had gone immediately to their physicians for examination.

At the present rate, one out of every 200 people in the state will contract venereal disease this year. The problem of the Bureau of Venereal Disease Control is to get individuals to suspect themselves. This show was planned to attract the most susceptible group. The movie acted by some of the nation's leading actors and prepared under the auspices of the United States Public Health Service is designed to convince them of the necessity for examination and immediate treatment.

HEARING CONSERVATION

Schools in fifty counties have requested the services of the Michigan Department of Health's two hearing consultants in testing the hearing of their children this year.

For the sixth year, the Department is providing the service as an aid in conserving the hearing of children and in helping those who do not hear well. Many more requests are received than can be fulfilled.

To find those children who have hearing difficulties, group hearing tests are given by local persons trained by Michigan Department of Health consultants. For this purpose, an audiometer—a phonograph with forty sets of headphones—is used. A record is played. A woman's voice repeats numbers in diminishing loudness. Each child writes down all the numbers he can hear.

If this test reveals that a child does not hear as well as he should, consultants of the Michigan Department of Health give the child an individual hearing test to determine the extent of his hearing loss. Local health department and school personnel follow up the hearing tests given by the consultants to see that each child with a hearing loss is taken to an ear specialist for examination and medical care.

More than 250,000 children have been examined for hearing loss since the Department's hearing program began in 1943. Of these children, 3 per cent showed some hearing loss. Of the children who received medical treatment, 75 per cent improved, about 50 per cent of them to normal hearing.

Improved hearing resulted in better school work, better social adjustment and in improved personality.

Requests for the hearing conservation program are made by the schools through local health departments.

PREMATURITY HIGH AMONG CAUSES OF DEATH

Prematurity took more Michigan babies' lives last year than all other causes and it was the seventh leading cause of death among the entire population of the state.

Reports made by physicians on death certificates showed that more than half of the 5,120 infant deaths in 1947 were from causes related to prematurity.

TYPHOID CARRIERS SEARCH REWARDED

There are 266 known carriers of typhoid fever in Michigan at the present time. The state's sixteen-year search for spreaders of the disease has revealed a total of 518 carriers, and cut both cases and deaths from typhoid fever drastically. A total of 424 new cases of typhoid fever and seventy-five deaths from the disease were reported in 1931. In 1947, there were seventy-seven new cases and five deaths. Michigan has had no case of typhoid fever due to a public water supply in the past fourteen years.

STUDY IN DEPARTMENT

Visitors from Iceland, Turkey, Siam, China, India, Panama, South America, the Philippines and Canada studied or observed work in the Department in July and August.

They included: Sigrun Magnusdottir, Chief Nurse of the Tuberculosis Department at Reykjavic Health Center, Iceland; Nusret Fisek, M.D., Government Official, Central Institute of Hygiene, Ankara, Turkey; S. Tantbirojn, M.D., of Pasteur Institute, Bangkok, Siam; C. J. Chen, M.D., Director, Kunning Branch of the National Vaccine and Serum Institute, Yunnan, China; Kang Fang, M.D., National Institute of Health, Ministry of Health, Nanking, China; Y. W. Wong, National Vaccine and Serum Institute, Temple of Heaven, Peiping, China; P. H. Chen, M.D., Director of the Department of Communicable Disease Control, Bureau of Health, Shanghai, Municipal Government, Shanghai, China; S. Seshagiri

(Continued on Page 1136)



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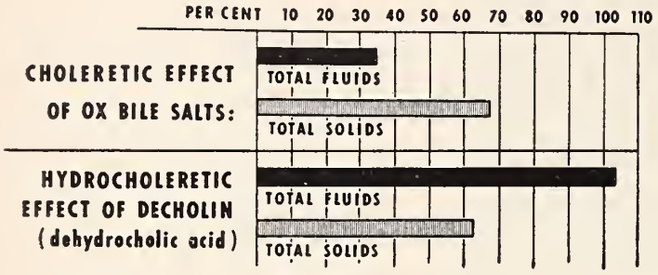
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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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STUDY IN DEPARTMENT

(Continued from Page 1134)

Rao, M.D., Health Officer of Bangalore City, India; and Richmond K. Anderson, M.D., of the International Health Division staff of Rockefeller Foundation in India.

From nearer places were: Guillermo C. Beleno, Technical Chief, Public Health Department, Panama City, Panama; Carlos Gomez, student from Bogota, Colombia; Amaury de Medeiros Filho, M.D., Ministry of Education and Health, National Department of Health, Brazil; Myrian Graca and Marina Rescende, student nurses of Brazil; Matilda Krueger and J. B. Escobar, Institute of Inter-American Affairs, students from Bolivia; and J. R. Arevelo, M.D., Institute of Inter-American Affairs, student from El Salvador; Mrs. Felicidad Diaz Elegado, assistant superintendent of nurse training, Jose R. Cruz General Hospital, Manila, the Philippines; Eduardo Duran Y. Jimenez, M.D., United States Public Health Service, Manila, the Philippines; and Miss Nolen, public health nurse of Alberta, Canada.

STATE SANATORIUM RATES RAISED

Michigan's state tuberculosis sanatorium rates were increased to $7.00 per patient, per day, effective August 15, 1948, as result of action by the State Tuberculosis Sanatorium Commission, subsequently approved by the State Administrative Board. Less the $3.50 per day state subsidy, which is deducted from the billing to the county, the net charge to counties for the care of tuberculosis patients in state sanatoriums is now $3.50 per day. For patients hospitalized in county, city and privately owned tuberculosis sanatoriums, counties will receive a monthly cash subsidy at the rate of $3.50 per patient, per day.

NEW ASSOCIATE DIRECTOR OF MATERNAL AND CHILD HEALTH

Fanny H. Kenyon, M.D., who has worked on the diarrhea and enteritis study with the Department for the past three and a half years has been appointed associate director of the Bureau of Maternal and Child Health of the Department.

Dr. Kenyon was graduated from Wayne University College of Medicine, interned at Grace Hospital, Detroit, was a resident at Children's Hospital, Detroit, and had special training in child development at Merrill Palmer School.

Dr. Kenyon was in private practice, and was plant physician at Chrysler Corporation prior to joining the staff of the Department.

INDUSTRIAL HEALTH PHYSICIAN KILLED

Victor C. Myers, M.D., thirty-four, Industrial Health physician with the Bureau of Industrial Health, was killed in an automobile accident, July 30.

Dr. Myers was graduated from Creighton University School of Medicine and interned at the United States Marine Hospital, Seattle. During the 1947-48 school year he was at Johns Hopkins School of Public Health where he received his Master of Public Health Degree.

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He was a member of the Ingham County Medical Society, the American Medical Association, the American Public Health Association, and the American Conference of Governmental Industrial Hygienists.

RAPID TREATMENT CENTER MANAGER DIES

Forrest D. (Bud) Beadle, forty-five, business manager of the Michigan Rapid Treatment Center since its establishment in July 1944, died suddenly September 5. Previous to coming to the Michigan Rapid Treatment Center, Mr. Beadle had special training in western Pennsylvania under Dr. John Stokes, head of the Department of Dermatology and Syphilology of the University of Pennsylvania. He had been employed by the Lansing City Health Department as a venereal disease investigator.

CALHOUN HEALTH DIRECTOR HONORED

Hugh Robins, M.D., director of the Calhoun County Health Department, has been appointed a member of the Advisory Committee to the United States Children's Bureau for a three-year period.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	August 1948	August 1947
Diphtheria	0	7
Gonorrhea	*775	906
Lobar Pneumonia	44	33
Measles	424	190
Meningococcic meningitis	6	7
Pertussis	132	1026
Poliomyelitis	204	133
Scarlet fever	85	115
Syphilis	*950	1148
Tuberculosis	483	628
Typhoid fever	6	6
Undulant fever	16	24
Smallpox	0	0

*Provisional Figures.



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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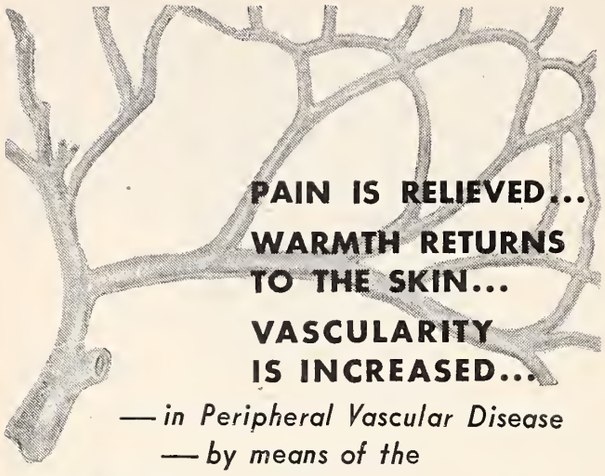
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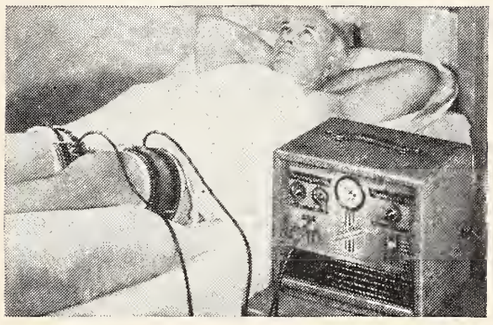
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Woman's Auxiliary

ANNUAL REPORT OF THE PRESIDENT



MRS. T. GROVER AMOS

As President of the Woman's Auxiliary to the Michigan State Medical Society for 1947-48, I submit the following report:

Michigan has again had a very busy year. It has been interesting to watch the growth of our Auxiliary from twenty-two County Auxiliaries last September to twenty-seven this fall, with an increase of nearly 300 members. I am not taking the credit, for all that we have accomplished this year has been due in great part to the groundwork laid by my predecessors and to the excellent co-operation received by the Organizational Committee: Mrs. Dixon, Mrs. Callery, and Mrs. Oscar Stryker.

There have been many meetings to attend this year. The activities incident to office consisted of:

1. *Presiding at Meetings.*—The postconvention Board meeting last September. The mid-year Board meeting in December. The special Board meeting in April. The pre-convention Board meeting held yesterday. This annual meeting.

2. *Attending the Following Meetings.*—The National Mid-Year Conference of State Presidents and Committee Chairmen held in Chicago last November. This Conference was inspiring, and we obtained many new ideas. The National President recommended at this meeting that the national dues be raised and that they be raised to include *The Bulletin.*

It was my privilege this spring to attend two State annual meetings—Ohio in April and Illinois in May. These meetings were very inspirational and educational to your President. It was most interesting to hear about the projects, problems, and accomplishments in these nearby states. The gracious hospitality in each state was almost unbelievable. It would seem that this would be an invaluable experience for a President-Elect while she is developing and working out plans for her next year's work. Your President recommends that exchange visits also be practiced among the County Auxiliaries. It has been our one desire to create a broader vision in Auxiliary work, instead of becoming too local minded or ingrown. New York's invitation could not be accepted, as I had already made my itinerary for visiting County Auxiliaries, and this date conflicted.

Of course, the most enjoyable part of the year was visiting twenty of our twenty-seven County Auxiliaries. Each Auxiliary seemed to have the door wide open and

Say you saw it in the Journal of the Michigan State Medical Society

the welcome sign out. I should like to say another thank you to each and every one of you for your generous hospitality.

The annual meeting of the Woman's Auxiliary to the American Medical Association was held in Chicago at the LaSalle Hotel in June. Mrs. Eustace A. Allen, President, conducted the meetings at which reports of national officers and chairmen were heard. Two-minute reports were given by each State President; Mrs. Luther H. Kice was installed as President for 1948-49 on June 23.

I feel sure that you will all be happy to know that we now have representation on the National Board. Michigan received recognition by having one of our own Past Presidents, Mrs. Lloyd C. Harvie, elected as Third Vice President. We are very pleased to have representation on the Board, as we feel it will keep us in closer touch with the national Auxiliary. We are very glad that Mrs. Harvie is our representative.

An overwhelming majority of states approved the amendment of the By-Laws to increase the dues to $1 and include a subscription to *The Bulletin* and a new magazine to be designed for physicians' wives. The subscription to *The Bulletin* and new magazine does not take effect immediately, but when authorized by the Advisory Council to the Woman's Auxiliary. Until enough funds are received from advertising to finance both this new publication and *The Bulletin,* we shall pay $1 for *The Bulletin* and $1 for national dues. This amendment went into effect as of June 23, 1948.

It was very gratifying to see all of Michigan's sixteen delegates there and together at all the business meetings. They, however, were in the minority group, voting against the high increase in dues. Tables were reserved for the Michigan delegation at the luncheons with as many as twenty-two present. Special thanks should be extended to all of these members who so seriously assumed their duties as delegates.

Only one *Auxiliary News* was published this year and mailed in October. Because of the increased expense of printing, it didn't seem feasible to send another issue. However, starting in January, five monthly *News Letters* were sent by your President to the Executive Board and members at large in an attempt to keep them up to date on the latest State developments.

Our Auxiliary is now twenty-two years old, with as bright a future before us as we have ever experienced, mainly, because our own parent society is realizing what tremendous importance we can be to them. Four important things have shown their confidence in us this year.

1. A letter sent by the President of the Michigan State Medical Society, Dr. P. L. Ledwidge, to all County Societies having no Auxiliaries telling them how important the Woman's Auxiliary is becoming and urging them to authorize forming one.

2. A talk given at the Secretarial Conference in Detroit last January by Dr. J. S. DeTar, Speaker of the House of Delegates of the Michigan State Medical Society, on "Our Responsibilities to the Woman's Auxiliary."

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3. An additional $500 was given us this year; $100 to help defray presidential expenses and $400 to help carry out our organizational work for the year of 1948. Results: Five Auxiliaries added and twenty-eight members at large from fourteen unorganized counties.

4. The brochures for the Woman's Auxiliary given you today were prepared and printed by the Public Relations Committee of the Michigan State Medical Society, in collaboration with Auxiliary members. It has an outlined program with suggested topics and speakers for your Public Relations Day in April and suggested programs and projects for 1948-49. This is the first time we have had planned material to give you at the beginning of the working year.

They have done innumerable other things for us for which we are very grateful, and I am sure as time goes on, they will feel that we are one of their important links in Public Relations work. Let us work harder and harder to show them that the added confidence they have placed in us is warranted.

In closing, may I say that without your wholehearted co-operation this report of accomplishment could not have been written, and thanks a million to all of the Board and Auxiliary members who have helped make this year so interesting and enjoyable. The friendships made not only in our state but in our neighboring states and, in fact, all over the states, are priceless.

(Mrs. T. G.) Louise W. Amos
President, MSMS Auxiliary

JAPAN MISSION

Another Michigan physician has been chosen for a foreign trip in the plan to take postgraduate medical education to the doctors in the military service overseas. Albert C. Furstenberg, M.D., dean of the University of Michigan Medical School and chief of the Otolaryngological Division, is now in Japan.

DIAGNOSIS AND TREATMENT OF CHANCROID

(Continued from Page 1121)

at weekly intervals for at least six more months. Unfortunately, it was the almost universal experience that these patients discontinued their treatment as soon as healing was well established and did not carry through with the prolonged course of treatment recommended. A clinical relapse almost invariably occurred within six to twenty-four months. It is hoped that this weakness of our previous treatment will be avoided in the present intensive methods of using streptomycin.

The following additional methods of treatment have been employed in the past, although it is not expected they will be indicated with the present streptomycin therapy. These included surgical excision and plastic repair, radiotherapy, oxidizing agents and penicillin to combat fuso-spirochetosis, and podophylin (20 per cent) locally in the exuberant granulation tissue types.

Say you saw it in the Journal of the Michigan State Medical Society

In Memoriam

ZAE R. ASCHENBRENNER, M.D., Farmington, Michigan, was born January 21, 1894, in Iowa City, Iowa, and graduated from the State University of Iowa College of Medicine in 1920. He was a past president of the Oakland County Medical Society, a member of the American Medical Association, and the Michigan State Medical Society. He served in the U. S. Army for fourteen months during World War I, and had been located in Farmington for twenty-six years. Dr. Aschenbrenner died of leukemia in Detroit, Michigan, on July 21, 1948, at the age of fifty-four.

JERRY M. JONES, M.D., Bay City, Michigan, was born February 19, 1871, in Parkhill, Ontario, Canada. He graduated from the Michigan College of Medicine and Surgery, Detroit, in 1896. He was Chief Surgeon for the Detroit-Mackinac Railway and had operated the Jones Clinic since 1917. In 1947, he was honored by Wayne University for fifty years of medical service. Doctor Jones was an Emeritus member of the Bay County Medical Society, American Medical Association and the Michigan State Medical Society. He passed on, on August 9, 1948, after an illness of two years, in Bay City, Michigan, at the age of seventy-seven.

GRANT McDONALD, M.D., Detroit, Michigan, was born in Southfield Township, November 17, 1869, and graduated from the Wayne University College of Medicine in 1900. He had been on the staff of the Florence Crittenden and Children's Hospital for many years. He was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Doctor McDonald died on August 23, 1948, in Detroit, Michigan, at the age of seventy-eight years.

VICTOR CAMPBELL MYERS, M.D., Lansing, Michigan, was born March 26, 1914. He graduated from Creighton University School of Medicine in 1940. Doctor Myers was a member of the Ingham County Medical Society, the American Medical Association and the Michigan State Medical Society. He was killed in an automobile accident near Muskegon, Michigan, on July 30, 1948, at the age of thirty-four.

INDIANA REPORTS

Chiropractors are working to get into the hometown medical care program of the Veterans Administration. A big and bitter fight is anticipated at the national American Legion convention in Miami, October 17-21, when a resolution demanding that VA permit chiropractors to treat veterans requesting their services comes before the convention. Chiropractors are trying to use the Legion to promote their interests. At the recent Indiana Legion convention a resolution was adopted asking the VA to permit chiropractors to care for veterans.—*Indiana SMS News Flashes,* September, 1948.

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Dear Doctor:

I am deeply interested in blood banks. Holland is a small city of 15,000 but serves a trade area of 40,000.

Before the war our hospital staff talked about the feasibility of installing a blood bank. At that time it seemed we were too small to operate a successful bank. Then the war came, and the whole idea was dropped. After the war, the thought of a bank was revived, due to the fact that whole blood therapy was given a tremendous boost during the war. Secondly, we saw that the American Red Cross was promoting whole blood programs here and there and we wanted to get going so that we could forestall any lay program; some of our G.I.s were talking blood; and the Eagles Lodge of Michigan at a State convention had appointed a Health and Welfare Committee—local members of which began talking blood bank and had offered two new electric refrigerators to the local hospital if they would install a blood bank. The idea began to jell on us from all sides. Then the American Red Cross began to set up an area bank at Muskegon, thirty-five miles north of us, and wanted us to come in under their set-up. However, we wanted to remain independent, and our County Medical Society, after careful discussion, decided to set up a whole blood program for the community. I was appointed to start the program and direct it. After about two months of organizational work we are operating a good blood bank. We have a large, especially built, refrigerator for storage at our local hospital. Neighboring small towns and hospitals are participating. The entire program is directed by and in the hands of the members of the County Medical Society. Storage facilities are owned and operated by our local hospital and this institution likewise does all necessary laboratory work. The Red Cross asked to participate in our donor program, and we have turned that over to them, but still under our direction; even publicity must pass through me. For this we promise to come under their direction in case of a local major disaster or a national emergency.

We have a blood letting center at the Red Cross chapter. They furnish all equipment but entirely according to our request, and the entire set-up is under my direction. They have a canteen to serve coffee and lunches during donor clinics. I wish you could see our set-up. We are very proud of it. We have gotten out a working manual, and everything is going smoothly. Of course, we have been in actual operation for only a month, and we run on to small bugs in the program which must be corrected, but our whole blood program is serving our community, and it is in the hands of the local medical men instead of lay groups. We have not gone into a plasma

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program yet because we do not know our needs for whole blood as yet.

After investigation, I soon saw that in any voluntary whole blood program, such as we have set up, the donor program is usually the weak link in the set-up. So we immediately supplemented the Red Cross Donor Program at the hospital. In other words, when a transfusion is given we urge the family to sign up for two or more donors to replace the first unit of blood and one for each subsequent unit of blood. These donors can give their blood at the hospital or be subject to call at one of the regular Red Cross Donor clinics which are held every week or so. This is done for two reasons—first, it helps keep up our donor program, and second if the Red Cross donor program falls down we can easily switch to a complete replacement program without much trouble. A charge of five dollars is made by the hospital for each transfusion; this is to cover handling, laboratory and storage. Each blood letting clinic is attended and conducted by two physicians rotating in order, according to a schedule.

We think we have the ideal set-up for a whole blood program in any small community and the small hospitals. We are giving our people a real service, not free, but at a cost within reach of all, and last but not least, in the hands of the local doctors where such a program is best administered and belongs.

The Eagles Lodge gave us the especially built refrigerator, costing six hundred dollars. Other lodges, the veterans organizations, industry and the rural areas are recruiting donors for us. Publicity is going out through local press, local radio station and local movie theatres. It has been a lot of work, but we are proud of our accomplishment. Programs such as this will keep medicine a free enterprize.

If our program interests other small communities in the state we will be glad to have them come down and look us over, and if we can be of help to them we are at their service.

Yours very truly,
O. Van Der Velde, M.D.

Aug. 12, 1948

THIS UNDER VOLUNTARY MEDICAL SERVICE!!

The expectation of life at birth among the industrial policyholders of Metropolitan Life Insurance Company *(Bulletin,* January, 1948) rose to an all-time high of 66.5 years in 1947, an increase of one year since 1946. The figure for the expectation of life last year represents a gain of ten years in the past two decades, and of twenty years since 1911-1912. The crude death rate last year was 7.2 per thousand as compared with 7.3 in 1946, the previous banner health year.

The decline in mortality for tuberculosis in 1947 was 9.6 per cent, close to three times the average annual decline for the preceding ten years. Contagious diseases established a new low rate of 1.3 per 100,000, almost a third below the previous minimum of a year ago.

Say you saw it in the Journal of the Michigan State Medical Society



. . . . . NEWS MEDICAL

Michigan's population jumped 813,000 to a total of 6,069,000 since 1940, an increase of 15.5 per cent.

* * *

Joseph A. Johnston, M.D., Detroit, is the author of an original article, "Nutritional Problems," which appeared in JAMA of August 28, 1948.

* * *

Clayton C. Purdy, a Detroit attorney, spoke to the Calhoun County Medical Society on "Medical Jurisprudence" at its meeting of September 14.

* * *

State Welfare Director W. J. Maxey predicts higher welfare loads because of the increasing number of persons older than sixty-five, the rise in living costs, a decline in savings and fewer jobs for aged persons.

* * *

There are 199,755 physicians in the United States, according to an AMA report. This is a 17 per cent increase since 1940—while the population, as a whole, increased only 12 per cent.

* * *

The American Society of Anesthesiologists, Inc., announces its annual meeting scheduled for St. Louis, November 4-5-6, 1948. The meeting will feature the first House of Delegates meeting of the ASA.

* * *

The first Scientific Assembly of the American Academy of General Practice will be held at the Netherland Plaza Hotel, Cincinnati, Ohio, Monday, Tuesday, Wednesday, March 7, 8, and 9, 1949.

* * *

Diabetes Week, sponsored by the American Diabetes Association, will be held throughout the Nation the week of December 6, 1948. For program, write Howard F. Root, M.D., Chairman, 81 Bay Street Rd., Boston, Mass.

* * *

World Health Organization: The United States was accepted into full membership in WHO at its plenary meeting in Geneva on July 2, 1948. James R. Miller, M.D., AMA Trustee, was one of the three United States Delegates to the WHO in Switzerland.

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, addressed the Fifth Annual Meeting of the Association of American Physicians and Surgeons at the Mayflower Hotel, Akron, Ohio, on Friday, October 1. His subject was "How to Develop Better Medical Public Relations."

The Second Annual Postgraduate Lectures of the American Academy of General Practice of Wayne County will be held in Detroit November 10-11, 1948. For copy of program write E. C. Texter, M.D., Secretary, 7457 Gratiot Avenue, Detroit 13, Michigan. (See page 1145.)

Hardy A. Kemp, M.D., resigned as Dean of Wayne University College of Medicine on September 21 to assume the Directorship of Postgraduate Medical Study at the Texas Medical Center, Houston.

All success, Dean Kemp, and happiness in your new location.

* * *

An unusual picture of the composition of the official United States Delegation to the recent international Congress on Mental Health held in London, August 11-21, was that the roster was 100 per cent federal employes! —Washington Report on Medical Sciences, July 19, 1948.

* * *

Under the U. S. Hospital Survey and Construction Act (Hill-Burton Act), work totaling $160,463,523 has been approved, to date, of which the federal share is slightly less than one-third. Among the latest applications to be approved is that of the Dickinson County Memorial Hospital of Iron Mountain, Michigan.

* * *

One of the interesting developments in the Congressional investigation of the spy ring has been the naming of Charles Kramer (born Krovitisky) as a Communist and a member of the ring. He was chief clerk of Senator Pepper's subcommittee on War Time Health and Education.—*American Medicine and the Political Scene,* August 6, 1948.

* * *

Veterans Administration needs a Chief Medical Officer in its sub-regional office at Escanaba, Michigan. Qualifications: license to practice in Michigan, general practitioner between 35 and 60 years of age. For further information write Thomas P. Cook, Michigan Medical Service, First National Bank Bldg., Marquette, Michigan.

* * *

Prescriptions for Private Patients.—Sir Ernest Graham Little asked on July 20 why the patients of doctors who remained outside the National Health Service were debarred from receiving free medicine although eligible for free treatment.

Mr. Bevan answered that the diagnosis, the prescrip-

(Continued on Page 1146)

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tion, and its provision must be treated as part of one process. He could not justify separating the prescription as Sir Ernest suggested.—*British Medical Journal.*

* * *

At the Ottawa Indian Naming Ceremony in Harbor Springs on Sunday July 25, the following Detroit physicians were adopted into the Tribe: D. R. Herkimer, M.D., Detroit, H. L. Smith, M.D., Detroit, C. W. Husband, M.D., Detroit. Other physician-members of the Tribe are: L. J. Gariepy, M.D., Detroit and R. A. C. Wollenberg, M.D., Detroit.

* * *

Veterans Administration collects insurance benefits due a veteran—and credits them towards the cost of the V.A. hospital care—if the veteran is hospitalized for a non-service connected disability, according to John W. Castellucci, Director of Veterans' Care Program, Michigan Medical Service. Veterans Administration makes no attempt to collect insurance benefits where the veteran is hospitalized for a service-connected disability.

* * *

The AMA Council on National Emergency Medical Service now has a full-time secretary in the person of Harold R. Hennessy, M.D., who has been associated with the AMA Council on Industrial Health since February, 1946. Dr. Hennessy's position is a newly created office, made necessary by the flood of work which is facing the Council. His office will be at 535 N. Dearborn Street, Chicago, Illinois.

* * *

The American Goiter Association will hold its annual meeting in Madison, Wisconsin, May 26-28, 1949. At this meeting the Van Meter Prize Award of $300 and two honorable mentions will be made for the three best essays submitted concerning original work on problems related to the thyroid gland. For information on the Awards write T. C. Davison, M.D., 207 Doctors Building, Atlanta, Georgia, not later than March 15, 1949.

* * *

Candidates for the American Board of Ophthalmology are now being accepted for the 1950 written test. Registration for the 1949 test is already closed. Practical examinations for acceptable candidates, 1949, will be held in New York June 11-15, 1949; in St. Louis October 15-19, 1949. For further information, write American Board of Ophthalmology, 56 Ivie Rd., Cape Cottage, Maine.

* * *

Two top AMA officials have been appointed to the Medical Advisory Committee of the National Security Resources Board which will advise on how medical manpower will be used in any future national emergency: E. L. Bortz, M.D., Philadelphia, immediate Past President of the AMA, and James C. Sargent, M.D., Milwaukee, chairman of the AMA Council on National Emergency Medical Service.

Congratulations, Drs. Bortz and Sargent!

* * *

The American Urological Association offers an annual award of $1,000 (first prize, $500; second prize, $300;

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third prize, $200) for essays on the result of some clinical or laboratory research in urology. The awards will be made at the AUA meeting, Biltmore Hotel in Los Angeles, May 16-19, 1949. For particulars, write Thomas D. Moore, M.D., 899 Madison Ave., Memphis 3, Tenn. Essays must be in the hands of the AUA Committee by February 15, 1949.

* * *

The American Medical Association is building a five-story addition to its headquarters at 535 N. Dearborn Street, Chicago, to provide 35,000 additional square feet, or approximately 25 per cent more floor space than it now occupies, according to George F. Lull, M.D., AMA General Manager and Secretary. The original AMA building was built in 1923 and modernized with two additional stories in 1936 and again with a three-story wing in 1941.

* * *

The National Society for Crippled Children and Adults, Inc. will hold its 38th convention at the La Salle Hotel, Chicago, November 15-17. Many outstanding speakers in the field of medicine, health and education, will be on hand to present facts on progress in work with the handicapped during the past year, according to Lawrence J. Linck, Executive Director. For program, write Mr. Linck at 11 S. LaSalle St., Chicago, Illinois.

* * *

The Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, N. Y., has appointed a Medical and Scientific Committee to guide the medical policies and activities of the Foundation in its attack on arthritis and related disorders. One of the functions of the Committee will include the development of programs to be undertaken by the Foundation's thirty-eight local chapters organized throughout the country.

Charley J. Smyth, M.D., Eloise, is a member of the Board of Directors of the Arthritis and Rheumatism Foundation.

* * *

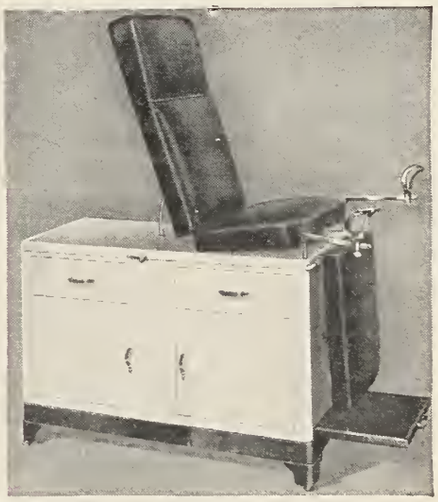
Callahan Act, requiring agents of foreign powers to register with the Secretary of State, has had an interesting, if ineffective, existence. After the legislature passed the law in 1947 Att'y-Gen. Black ruled the act unconstitutional. Sufficient petitions calling for a referendum on the question were filed to place it on the November ballot. The present status is that two Wayne County "taxpayers" have filed a petition in the Supreme Court to take it off the ballot because it had been ruled unconstitutional. Now the author, Senator Callahan, has intervened with the Supreme Court in an attempt to keep the question on the ballot. The Court is expected to hear the case August 24.—*Michigan Survey,* August 16, 1948.

* * *

Surgery of Harelip and Cleft Palate.—It has been brought to the attention of the Michigan Crippled Children Commission by oral and plastic surgeons that an increasing number of children with harelip and cleft palate are being referred to hospitals for consideration of

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cheilorrhaphy and/or palatorrhaphy at a time not optimal for the indicated surgical procedure. Some of these cases are being brought in to the hospitals when they are merely a few days to two weeks of age. The optimal time for the cleft lip repair is at the age of one month, and the desirable time to begin cleft palate surgery is eighteen months to two years of age.

In a combined cleft lip and palate case, the same holds true with the lip being repaired at the age of one month and the palate at eighteen months or two years of age.

The co-operation of the local referring physicians is required in following out the recommendations that have been made to the Crippled Children Commission relative to the referral for treatment of this type of case.

* * *



Charles S. Stevenson, M.D., has been appointed as a full-time Professor of Obstetrics and Gynecology at Wayne University College of Medicine. Dr. Stevenson holds a Bachelor's degree from Princeton University and his M.D. degree from Johns Hopkins where he served as a faculty member. During the war he was in both Italy and the Pacific Theatre with the Navy. He comes more recently from postgraduate work at Boston Lying-in Hospital with Duncan Reid, M.D.

* * *

S. W. Hartwell, M.D., president of the Muskegon County Medical Society, stated the following truths in his "President's Paragraph" of the *Muskegon County Medical Society Bulletin* of July, 1948:

"Think of the benefits which would accrue if all people, both those within and those without the Medical profession, paid attention to these rules of the profession! There would be no cults to prey upon the people. "Public Relations" would be no problem. The "Cost of Medical Care" would fall into its normal, logical position along with the costs of other necessities and demanded luxuries. And those with political ambitions would find it difficult to make a political issue out of Health or out of Ill Health and its treatment.

"Perhaps we doctors could best set our house in order and influence more votes wisely if we publicized our Code of Ethics more widely by precept, by example and by press!"

* * *

Talks on medical economics at Wayne University College of Medicine: Four practitioners of medicine, members of the Michigan State Medical Society, recently conducted a course of lectures on medical economics at Wayne University College of Medicine.

J. S. DeTar, M.D., Milan, Speaker of the MSMS House of Delegates, spoke on "Rural Medicine" on September 28.

R. L. Novy, M.D., Detroit, President of Michigan Medical Service, presented "Medical Service and the Distribution of Medical Care," on October 5.

L. Fernald Foster, M.D., Bay City, Secretary, Michi-

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gan State Medical Society, discussed "Medical Ideals and Business Relations" on October 12.

E. F. Sladek, M.D., Traverse City, President, Michigan State Medical Society, talked on "Medical Organizations" on October 19.

The talks were presented to the members of the senior and junior classes and to interns and residents associated with Receiving Hospital. Each lecture was one hour in length.

* * *

Blue Cross has been chosen by the Ford Motor Company and the UAW-CIO as the program of hospital-surgical protection for Ford employes throughout the United States. The decision to make Blue Cross available to Ford employes and their families followed intensive study by union and management committees. The chief reasons for selecting Blue Cross are the service benefit features of these non-profit plans and their economical operating methods. Approximately 300,000 men, women and children will be eligible for Blue Cross protection through this group. Two hundred thousand of these are Ford workers and their dependents in Michigan. Michigan Hospital Service and Michigan Medical Service, the Blue Cross Plans in this state, will enroll the Michigan employes, and 30 Blue Cross plans throughout the country will enroll the out-of-state employes. A program of non-profit hospital-surgical protection, Blue Cross is sponsored by the American and state hospital associations and by the state medical societies in all parts of the United States including Michigan.—*The Detroit Medical News,* September 6, 1948.

Highland Park Clinic Day

The Highland Park Physicians' Club and Staff of the Highland Park General Hospital are having their Annual Clinic Day at Highland Park General Hospital on November 3, this year. They plan one of the best programs in their nineteen-year history, and all members of the Michigan State Medical Society are invited to attend.

Program

Morning Session—8:30 a.m.

C.P.C.—Viola Brekke, M.D., Detroit

Symposium on "Rehabilitation"
Donald A. Covalt, M.D., New York
Helen Flanders Dunbar, M.D., New York
Gershon J. Thompson, M.D., Rochester, Minnesota
Panel Discussion

Luncheon—12:00 Noon

Afternoon Session—2:00 p.m.

"Chemical Background of Medical Treatment"
Slater Lewis, M.D.—Montreal
"Problems in Obstetrical Urology"
Houston Everett, M.D., Baltimore
"Surgical Treatment of Hypertension"
John Shirer, M.D., Pittsburgh

Evening Session—7:00 p.m.

Cocktail Hour—Hotel Statler

Dinner—Hotel Statler
Toastmaster—Jos. A. Witter, M.D.
Address—"Nazi M.D.'s at Nuremberg"—Judge Victor Swerengen



High School Athletic Accident Benefit Plan.—The Athletic Benefit Plan of the Michigan High School Athletic Association has just concluded its eighth year of operation. This plan was established during the 1940-41 school year as an aid to member schools to help in meeting at least part of the expenses incurred in connection with athletic injuries received by students participating in their athletic, physical education, and intramural programs. In the eight years of operation of the Benefit Plan, 1940-41 through 1947-48, there have been 10,935 claims paid to member schools. There were 689 member schools and 31,476 registered students during 1947-48.

During the 1947-48 school year, one injury benefit claim was paid for each twelve registered students, or 8.4 per cent. Of the 2,629 allowed injury benefit claims paid, however, there were 1,172 or 44.6 per cent, which covered x-rays negative to fracture or dislocation. If the number of x-rays negative to fracture or dislocation is deducted from the total number of injury claims paid (2,629) it results in there having been 1,457 injuries received which were included in the scheduled payments. This means, then, that the actual scheduled benefits, exclusive of x-rays negative to fracture or dislocation, were paid for 4.6 per cent of the 31,476 registered students (one in twenty-two) during the 1947-48 school year.

Following are some significant data comparing the operation of the Benefit Plan during the 1946-47 and 1947-48 school years:

1. Number of member schools—689 (85 more than in 1946-47).
2. Number of registered students—31,476 (3,352 more than in 1946-47).
3. Number of reported injuries—3,729 (649 more than in 1946-47).
4. Number of allowed injury benefits (claims paid)—2,629 (434 more than in 1946-47).
5. Number of claims withdrawn or not allowed—1,100 (215 more than in 1946-47).
6. Membership and student registration fees received from 689 member schools—$51,392.50 ($5,260.25 more than in 1946-47).
7. Amount paid to member schools on 2,629 allowed injury benefits—$48,928.38 ($9,424.95 more than in 1946-47).
8. Average amount paid on 2,629 claims—$18.61 ($0.62 more per claim than in 1946-47).

* * *

Patient Admitted to Hospital Every Two Seconds Last Year

CHICAGO—During 1947 one patient was admitted to a hospital in the continental United States every two seconds and a live baby was born in a hospital every 11 seconds, according to the 27th annual report of the Council on Medical Education and Hospitals of the American Medical Association.

Four physicians—F. H. Arestad, E. H. Leveroos, W. R. Albus, and W. W. Corbett—present the council report in the August 14 issue of *The Journal of the American Medical Association.* Their figures reveal that in comparison with 1946 the number of hospital beds has decreased from

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1,468,714 to 1,425,222 and the number of admissions has increased from 15,153,452 to 15,829,514.

This apparent discrepancy is clarified when the average length of stay per patient in general hospitals is considered. In 1946 the average patient remained 12.9 days in a general hospital; in 1947 he was discharged after 11.4 days, a gain to the patient of a day and a half. The number of patient-days has decreased from 452,400,710 to 444,288,585.

Represented in the report are 6,276 hospitals registered by the American Medical Association, including 1,909 approved for internships and residencies and 2,609 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals is four less than reported in 1946.

The decrease in total bed capacity is accounted for entirely in the government group of hospitals, federal hospitals alone reporting 51,282 beds less than last year. With admission to the government hospitals decreasing by nearly 394,000, admissions to civilian hospitals increased by more than 1,000,000 for the second consecutive year.

Births reported passed the two million mark (2,136,373) for the first time in 1946; during 1947 births in registered hospitals reached the still higher figure of 2,837,139.

Of every 1,000 patients entering these hospitals during 1947, 926 were admitted to general hospitals, 18 entered neuropsychiatric institutions, 14 were admitted to related institutions including convalescent homes, ten to isolation units, seven to eye, ear, nose and throat, six to tuberculosis sanatoriums, six to maternity hospitals, six to children's, four to industrial, and three to orthopedic hospitals.

There were 15,829,514 admissions exclusive of outpatients and newborn infants in all registered hospitals during 1947. For comparison it may be noted that in the period 1933 to 1945 the hospital admissions increased from 7,037,982 to 16,257,402. The greatest annual gain, a total of 2,829,088, occurred in 1943, with subsequent increases of 662,150 in 1944 and 220,554 in 1945. This trend was sharply reversed in 1946 when the number of admissions decreased by 1,103,950; however, 1947 shows an increase of 676,062 admissions.

The government hospitals with 72.3 per cent of the bed capacity reported 4,204,344 admissions or 26.5 per cent of all patients admitted in 1947. The non-government hospitals with 27.7 per cent of the beds had 11,625,170 admissions, or 73.5 per cent. The corresponding ratios in 1946 were 33 and 67 per cent.

The general hospitals continue to offer a tremendous volume of hospital service, as evidenced by the report of 14,665,195 admissions in 1947, or 92.7 per cent of all patients admitted.

The mental hospitals with a total of 680,913 beds had 291,954 admissions, or 1.8 per cent of all patients admitted in 1947. In comparison with last year there was an increase of 20,745 admissions with gains reported in all government and non-government classifications.



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Tuberculosis hospitalization remains about the same with a total of 99,080 admissions in the tuberculosis sanatoriums as compared with 99,741 in 1946.

The enormous volume of service rendered by hospitals in the United States is likewise reflected in the daily patient load, which averaged 1,217,229 in 1947 exclusive of newborn infants. Compared with 1946, the daily census shows a decrease of 22,225.

The occupancy rate for the general hospital group to which 92 per cent of all patients were admitted decreased from 77.4 per cent in 1946 to 77.1 per cent in 1947. The percentage of beds occupied in government hospitals shows an increase in 1947 for all groups except the hospitals operating under federal control. The percentage of beds occupied in nervous and mental hospitals increased from 94.2 in 1946 to 95.7 in 1947 and nervous and mental diseases still account for more than half of the patients occupying hospital beds. Of the average census of 1,217,229 patients, 53.5 per cent were in hospitals of this type.

Registered hospitals reported employing 167,354 graduate nurses exclusive of 30,996 private duty nurses during 1947. The corresponding figures for 1946 were 146,602 and 28,245.

In connection with the present survey, state accredited schools of nursing reported a student enrollment of 94,133 as compared with 112,885 in 1946. This reduction in student personnel is indicative of the difficult nursing problem now facing the hospital field and the country at large.

Hospitals are making more and more use of practical nurses and attendants, the figure for this group being 23,654 greater than in 1946.

* * *

ONE HUNDRED AND FIFTY-SEVEN ATTEND 1948 CONFERENCE ON VENEREAL DISEASES DIAGNOSIS-TREATMENT

The medical profession's enthusiastic response to the one-day program on "Modern Diagnosis and Treatment of Venereal Diseases" was gratefully recorded by the sponsors, the Michigan State Medical Society, Department of Postgraduate Medical Education of the University of Michigan, and Wayne University College of Medicine. A total of 157 attended the V.D. meeting held at the Detroit Intensive Treatment Center, Herman Kiefer Hospital, on March 13, the day following the second Michigan Postgraduate Clinical Institute. Speakers included L. W. Shaffer, M.D., Detroit; George Sewell, M.D., Detroit; Udo J. Wile, M.D., Ann Arbor; H. L. Keim, M.D., Detroit; Steven F. Horne, M.D., Ann Arbor; Arthur C. Curtis, M.D., Ann Arbor; G. D. Cummings, M.D., Lansing, and John A. Cowan, M.D., Lansing.

The list of registrants at the Venereal Diseases Conference included:

Mrs. Bertha Allbritain, R.N., Port Clinton, Ohio; J. K. Altland, M.D., Lansing; C. P. Anderson, M.D., Detroit.

L. K. Babcock, M.D., Detroit; C. D. Baird, M.D., Windsor, Ont.; Arthur G. Baker, M.D., Allegan; C. L. Becklein, M.D., Detroit; L. E. Beeuwkes, M.D., Dearborn; S. A. Bennett, M.D., Detroit; W. G. Bennett, M.D., Detroit; Louis Beresh, M.D., Detroit; H. K. Board, M.D., Hamilton, Ont.; A. W. Boddie, M.D., Detroit; I. Botvinick, M.D., Detroit; K. E. Blair, M.D., Detroit; C. F. Boothby, M.D., Hartford; C. O. Brocious, M.D., Fort Custer; Pauline T. Buchman, R.N., Sandusky, Ohio; H. B. Burnside, M.D., Dearborn; I. M. Burstein, M.D., Detroit; Morris M. Burstein, M.D., Detroit.

A. L. Chapman, M.D., Detroit; R. A. Charleston, M.D., Detroit; Geo. M. Childs, M.D., Detroit; A. A. Cintron-Rivera, M.D., Ann Arbor; H. L. Clark, M.D., Detroit; Emilie Arnold-Clarke, M.D., Lansing; F. C. Clifford, M.D., Toledo, Ohio; C. G. Constable, M.D., Detroit; H. E. Cope, M.D., Lansing; E. L. Copeland, M.D., Decatur; S. O. Cotton, M.D., Detroit; C. J. Courville, M.D., Detroit; John A. Cowan, M.D., Lansing; Arthur C. Curtis, M.D., Ann Arbor.

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John Gardiner, M.D., Detroit; S. Gingold, M.D., Detroit; H. M. Golden, M.D., Flint; C. Gooch, M.D., Hamilton, Ont.; James D. Goodman, M.D., Detroit; S. S. Gorne, M.D., Flint; R. Greenridge, M.D., Detroit; A. J. Griffith, M.D., Detroit; J. J. Gutow, M.D., Flint.

E. A. Hand, M.D., Saginaw; James L. Henderson, M.D., Detroit; Owen S. Hendren, M.D., Birmingham; Ruth Herrick, M.D., Grand Rapids; Stephan F. Horne, M.D., Ann Arbor; Tang Hsiol Huer, M.D., Detroit; James J. Hughes, M.D., Columbus, Ohio.

E. A. Irvin, M.D., Detroit.

Z. L. Kaminski, M.D., Detroit; H. C. Keenan, M.D., Sarnia, Ont.; H. L. Keim, M.D., Detroit; Victor A. Kelmenson, M.D., Detroit; Howard A. Klein, M.D., Detroit; David Kliger, M.D., Detroit.

Paul C. Laird, M.D., Detroit; Wm. E. Laur, M.D., Detroit; Louis S. Leipsitz, M.D., Detroit; E. Lipkin, M.D., Detroit; Duane D. Love, M.D., Sandusky, Ohio; Adolf W. Lowe, M.D., Detroit.

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Mildred V. Nicholas, M.D., Saginaw; John Norup, M.D., Berkley.

Alex Olen, M.D., Detroit; Jay Overmyer, M.D., Detroit; Walter Lee Owens, M.D., Detroit.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

MEDULLARY NAILING OF KUNTSCHER. By Lorenz Bohler, M.D., Director of the Hospital for Accidents in Vienna, Professor of Surgery at the University of Vienna. First English edition revised by the author, translated from the eleventh German edition by Hans Tretter, M.D., Surgeon-in-Charge of the New Jersey Manufacturers Hospital, Active Consultant in Traumatic Surgery at the Orthopedic Hospital, Trenton, N. J., former Assistant to Dr. Bohler at the Hospital for Accidents in Vienna, former Demonstrator of Anatomy, University of Graz, Austria. Baltimore: Williams & Wilkins Co., 1948. Price, $7.00.

This book was originally published in German as the third volume of Bohler's work on fractures. In reviewing this book, it is astounding to note the great number of case histories of a new method on the treatment of fractures of the long bones that have accumulated in so short a period of time. Probably the first knowledge of medullary nailing came to this country by way of our wounded war prisoners who had this procedure done in German military hospitals.

Kuntscher first described his new method of treating fresh-closed fractures of the long bones in 1940. This method consists of the insertion of a long, strong and suitably shaped steel rod through a small incision distant from the fracture site into the bone in such a manner that the fragments are so firmly united with each other that the limb can be lifted immediately and moved actively in one to two weeks. Since that time, this new method of internal fixation has been carried out extensively in the Accident Hospital in Vienna under the direction and supervision of Dr. Bohler.

Dr. Bohler reports on some 600 cases, as well as, 12,000 roentgenograms that have come under his observation. He has covered the surgical technique used in inserting the nail in the various bones which are suitable for this type of fixation, the armamentaria required, the indication, contraindications and the complications. The book is profusely illustrated with roentgenograms of various types of fractures at different stages of healing.

This text is a "must" for those doing the surgery of trauma.

N. H. A.

A HISTORY OF THE HEART AND THE CIRCULATION. By Fredrick A. Willius, M.D., M.S., in Med., Senior Consultant in Cardiology, Mayo Clinic; Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota and Thomas J. Dry, M.A., M.B., Ch.B., M.S. in Med., Consultant, Section of Cardiology, Mayo Clinic; Associate Professor of Medicine, Mayo Clinic; Associate Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. Illustrated. Philadelphia: W. B. Saunders Co., 1948. Price $8.00.

Two Mayo Clinic Professors of Medicine have compiled in this book a very interesting history of the heart and circulation. The last section of the book begins with the period of 3000 B. C. to 2500 B. C., Imhoteb and his studies. Then the Ebers Papyrus and every reference to the heart and its anatomy and circulation, Ancient Egypt, China, Greece, Hippocrates, Aristotle, Galen, down to modern times. This is a very learned re-

search. The rest of the book is devoted to life sketches and pictures, where possible, of all of the great leaders who have contributed to the development of our knowledge of the heart and circulation, from Paracelsus, Vaesalius, Galen, Heberdine, Boerhaave, Lavoisier, Stokes, Bright, Flint, Trosuseau, Roger, Mitchel, Welch, and our own George Dock, to mention just a few. The book is well written and should be in the library of everyone interested in heart diseases and the history of medicine.

GENERAL ENDOCRINOLOGY. By C. Donnell Turner, Ph.D., Associate Professor of Zoology at Northwestern University. New, 1st edition. 604 pages with 164 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.75.

The subject of endocrinology gets altogether too little attention in our schools. Most of the material available is highly experimental and theoretical. This book is written to give the subject a closer study, detailed, but not involved. It is intended for the student who does not already know the subject. It is an intriguing work, and a storehouse of information for the busy practitioner.

VASCULAR DISEASES IN CLINICAL PRACTICE. By Irving Sherwood Wright, M.D., Associate Professor of Clinical Medicine, Cornell University Medical College; Chief of Section on Vascular Diseases of the Department of Medicine, New York Hospital. Chicago: The Year Book Publishers, Inc., 1948. Price $7.50.

This is one of the series of General Practice Manuals, and gives a comprehensive review of the vascular diseases. It is not a study of local lesions but of the system in general, giving the best known pathologic lesions and remedies. The book is compact, very readable, and well illustrated. There is a chapter on such things as frost-bite, trench foot and chilblains (Pernio), all of which are produced by temperature changes. The chapter on thrombophlebitis and phlebothrombosis is worth the whole book. A worthwhile addition to the general practitioner's library.

TREATMENT OF HEART DISEASE. By William A. Brams, M.S., M.D., Ph.D., Associate Professor of Medicine, Northwestern University Medical School, and Attending Physician, Michael Reese Hospital, Chicago. New, 1st edition. 195 pages, with 11 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $3.50.

The first quarter of this book is devoted to the pharmacologic action of drugs. Then follow very good outlines of treatment of various conditions with details to follow, cautions of what to avoid, and warnings about overtreatment in cases, for instance overtreatment of diabetes in the presence of coronary disease, because such cases do better with a high blood sugar, or some spillover of sugar in the urine. There is a very good chapter on the risks of surgery in cardiac cases, with the statement that local anesthesia, procaine without epinephrin is usually quite safe. The book is small but full of good thoughts and hints.

ORAL VACCINES AND IMMUNIZATION BY OTHER UNUSUAL ROUTES. By David Thomson, O.B.E., M.B., Ch.B., D.P.H., Director of the Pickee-Thomson Research Laboratory; Robert Thomson, M.B., Ch.B., Pathologist, St. Paul's Hospital, London. Assisted by James Todd Morrison, M.D., D.P.H. (Aberdeen). Baltimore: The Williams and Wilkins Co., 1948.

Prevention of disease is always our first objective, and this book suggests methods of prophylaxis by the oral route which are growing in acceptance. The Aztecs chewed poisonous ivy leaves as a prophylaxis. Mithridates



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ate small quantities of poison mushrooms as a means of protecting him from their poison. Pasteur was the first to realize the possibility of using oral vaccination against micro-organisms. Such is the historical sketch. Many attempts have been made, and with success, to develop oral methods of vaccination against toxins, bacteria, typhoid fever dysentery, tuberculosis, the latter of which, tuberculosis, gets about a hundred pages of the book. Tetanus, colds, measles, diphtheria, all are studied and reports of accomplishments given. This book is a careful report, a thorough review of the literature of the subject, and valuable because it opens up a trend of thought.

ESSENTIALS OF PUBLIC HEALTH. By William P. Shepart, B.S., M.D., M.A., with the collaboration of Charles Edward Smith, M.D., D.P.H., Rodney Rau Beard, M.D., M.P.H., and Leon Benedict Reynolds, A.B., Sc.D. With a Foreword by Ray Lyman Wilbur, M.D., LL.D., Sc.D., Chancellor, Stanford University, Ex-Secretary of the Interior, formerly President of Stanford University. Philadelphia: J. B. Lippincott Company, 1948. Price $5.00.

The general practitioner is called upon by the general public at all times to give information on public health matters, and must have an authoritative source of information. That need is covered by this book which gives exact rules, plans, regulations, instructions for construction of devices for health and sanitary installations, sewer disposal, septic tanks, contagious hospitals, et cetera. Every well-informed practitioner should be able to give the help and advice asked by his patients, and it is available here.

PRACTICAL THERAPEUTICS. By Martin Emil Rehfuss, M.D., F.A.C.P., Professor of Clinical Medicine, and Sutherland M. Prevost, Lecturer in Therapeutics, Jefferson Medical College, Philadelphia, Attending Physician, Jefferson Medical College Hospital; F. Kenneth Albrecht, M.D., formerly Clinical Director U. S. Marine Hospital, Baltimore, Md., and Co-director, Division of Tuberculosis Control, Kansas State Department of Health; and Alison Howe Price, A.B., M.D., Assistant Professor of Medicine, Jefferson Medical College, Philadelphia, Assistant Physician to Jefferson Medical College Hospital, Philadelphia. Baltimore: Williams & Wilkins Company, 1948. Price, $15.00.

This text was written primarily for the students of Jefferson Medical College to cover in a comprehensive volume the field of practical therapeutics. Thirteen contributors have made a very readable and systematic book that will be a help to any practitioner. Pages are devoted to introductory remarks, planning the program of care, which is far from the old methods of hit or miss. Now every step has a basis in proven results. Diagnostic survey, following general therapeutic principles, a course in prescription writing, use of capsules, drops, powders, suppositories, liquids, and dietary are given attention, then symptomatic treatment outlines what to do for acute abdominal emergencies, acidosis, alkalosis, anuria, ascites, and down through the alphabet, ending with tetany, tic, and vertigo. Prescriptions, and diagrams that are useful, are included. The balance of the book, about 600 pages, is devoted to treatment of specific disorders, and is very complete. The book has large pages, printed in two columns largely in outline style, and in elaborate detail, without the minutiae of drug actions which are so confusing in the average book.



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HANDBOOK OF OPHTHALMOLOGY. By Everett L. Goar, A.B., M.D., F.A.C.S., Professor of Ophthalmology, Baylor University College of Medicine, Houston, Texas. With 48 text illustrations and 7 color plates. St. Louis: C. V. Mosby Co., 1948. Price $5.50.

This book is based upon a series of lectures to Junior medical students at Baylor University, and serves as an outline for studies in conjunction with other work. It is brief, but gives a working knowledge of the methods of examination, the facilities and instruments available, and the important disorders to be studied and expected. It is a useful book for one who has to do some ophthalmology with other practice.

MORE THAN ARMIES? The Story of Edward H. Cary, M.D. By Booth Mooney, with an introduction by Dr. Morris Fishbein. Dallas, Texas: Mathis, Van Horn & Company, 1948. Price $5.00.

Dr. Cary served the medical profession in many ways, as president of the American Medical Association, member of the Board of Trustees, chairman of the National Physicians Committee, and in many other capacities too numerous to mention. His life is full and interesting, being an inspiration to everyone who knew him. He was known here in Michigan through his varied activities, especially to those working in the same vineyard—service to the ideals and objectives of the profession.

DIAGNOSIS IN GYNAECOLOGY. A Classification of Gynecological Diseases Based on Aetiology and the Clinical Logic for Diagnosis. By James V. Ricci, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Director of Gynaecology and Obstetrics, Columbus Hospital; Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynaecology and Obstetrics, Beekman-Downtown Hospital, New York; Fellow of the New York Academy of Medicine. Philadelphia: Blakiston Co., 1948.

The author has drawn upon his great experience and produced a new book designed to supplement the texts now in use. Demonstrations given the students at the New York Medical College form the foundation of this book. It is intended to simplify and make more direct the diagnosis in this field of medicine, being short and direct, and giving sufficient information to be a reliable guide.

INFLUENZAL MENINGITIS

Recovery from influenzal meningitis is more prompt and complications are fewer when treatment by spinal puncture is omitted, according to Archibald L. Hoyne, M.D., and Rowine Hayes Brown, M.D., from the Municipal Contagious Disease and Cook County Hospitals, Chicago.†

Influenzal meningitis is a type of inflammation of the three membranes which envelop the brain and spinal cord. It is caused by an influenzal virus, but its symptoms resemble those of other types of bacterial meningitis.

Rare in adults, the disease was formerly almost universally fatal. The sulfonamide compounds, specific anti-influenzal serum and streptomycin have all made the picture more optimistic, but even today there is no standard accepted for their application. Many doctors still believe that numerous spinal taps for drainage are necessary even after diagnosis has been established by spinal tap. Furthermore, when the National Research Council released streptomycin for treatment it advised that the new antibiotic be injected by spinal puncture.

The Chicago doctors' conclusion is based on a dozen years of experience in the treatment of meningitis. In their article they report specifically on fourteen consecutive patients with influenzal meningitis treated at the County hospital in 1946 and 1947 and sixteen consecutive patients treated at the Municipal hospital in 1946. There was only one death in each group, and in both of the fatal cases the patients had been given streptomycin by spinal puncture as well as intramuscularly. On the other hand, twenty-three of the twenty-eight patients who recovered had received no treatment by spinal puncture after diagnosis. These twenty-three had been given streptomycin intramuscularly, had been treated with serum, or had received sulfonamide compounds—sometimes all three.

"The primary purpose for a lumbar puncture should be to establish a diagnosis," Dr. Hoyne and Dr. Brown conclude.

†See JAMA, Feb. 28, 1948

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Personal Course in Gastroscopy, two weeks, starting November 8.
Gastroenterology, two weeks, starting October 25.
Hematology, one week, starting October 4.

DERMATOLOGY—Formal Course, two weeks, starting October 4.
Clinical Course every two weeks.

OPHTHALMOLOGY—Refraction Methods, four weeks, starting October 11.
Ocular Fundus Diseases, one week, starting November 15.

OTOLARYNGOLOGY—Intensive Course, two weeks, starting October 18.

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COUNTY MEDICAL SOCIETIES

Every month we receive announcements of the organization of new medical societies. In the words of Dr. Louis H. Bauer, Hempstead, New York, "in many communities the county medical society is merely another society." In some Illinois counties the hospital staff meetings replace the meetings of the county society. Frequently, the county medical society meets for business purposes only.

In every community it is the county medical society which should be considered the logical professional society to which all matters pertaining to health and medical care should be referred. Every ethical physician should belong to his county medical society, and the society should meet regularly for scientific meetings as well as for business sessions.

There has never been a time in our country's history when it has been more necessary to have powerful medical societies in every county. With an increasing demand for better health, sanitation and welfare conditions, the county medical society should be the important group in every community.

Physicians should be prepared to talk before local groups upon request. Dinner clubs, women's clubs, the P.T.A., and many similar organizations in the average community look to the medical profession for assistance in solving various community problems.

It is hoped that the county medical society will no longer be looked upon as "just another society" but will be reestablished as a powerful and important organization.—From *Illinois State Medical Society News Letter.*

A-I NEWS COVERAGE AT ANNUAL SESSION

Excellent newspaper coverage was given the Michigan State Medical Society's 83rd Annual Session and Postgraduate Conference in Detroit, September 21-25.

It is difficult to estimate the amount of space devoted to the Session by the science and the news writers, but from the flood of clippings received at the MSMS Executive Offices it appears that at least 300 Michigan newspapers carried one or more stories and that the three Detroit dailies averaged six major stories each.

The spirit of friendship and co-operation displayed by the newspapers of Michigan was admirably summed up by the *Detroit Times* in an editorial headed "Important Convention" which read as follows:

"Four thousand doctors, members of the Michigan State Medical Society, are in Detroit this week.

For the 83rd year the physicians are taking a few days off from their practices.

And for the 83rd year, they are devoting their few days to learning how better to treat their patients—meaning all of us who ever have need to call a doctor.

A full schedule has been set up to enable each doctor to learn newer development in his particular specialty or to learn how to be just a little better family doctor.

It is this constant devotion to healing, to preventive medicine, to easing hours of pain that has characterized the doctor since he carried his instruments and drugs in saddle bags and rode miles on horseback.

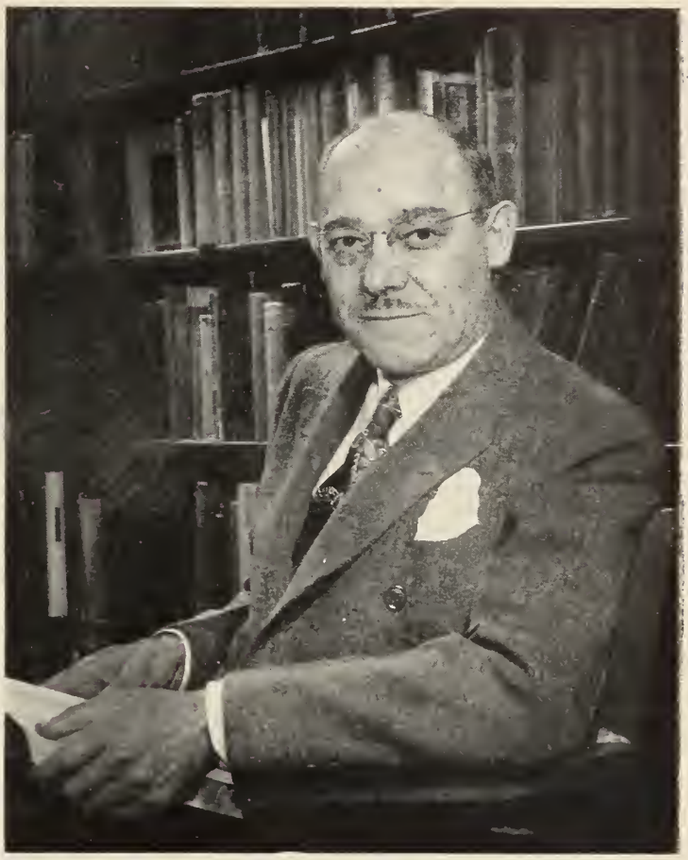
This is a good record to remember when bureaucrats who know nothing about the subject wish to put medical treatment on a production line or mail-order basis in the form of socialized medicine."



THE COUNCIL CHAIRMAN AND THE PRESIDENT-ELECT

O. O. Beck, M.D., Birmingham, and W. E. Barstow, M.D., St. Louis, at the 1948 MSMS Annual Session, Detroit.

Photos by Dale Rooks



THE MSMS PRESIDENT

E. F. Sladek, M.D., Traverse City, President of the Michigan State Medical Society, for 1948-1949.

Some of the most widely played stories dealt with talks delivered by Biddle Orator Edward A. Strecker, M.D., Philadelphia, Pa., "Compromise or Chaos"; Fletcher D. Woodward, M.D., Charlottesville, Va., "Medical Criticism of Modern Automotive Engineering"; and C. C. Burlingame, M.D., Hartford, Conn., "Good Psychiatry is Good Medicine."

Among the pictures published by the papers were those of President E. F. Sladek, M.D., Traverse City; President-Elect W. E. Barstow, M.D., St. Louis; Edward A. Strecker, M.D., Philadelphia, Pa.; and Guest Essayist John B. Barnwell, M.D., Washington, D. C.

While Detroit and outstate newspapers were co-operating 100 per cent in bringing the work of the medical profession before the public, the Canadian press also was represented for the first time at an MSMS Annual Session. Ray Martin of the *Toronto Star* covered the meeting, and his stories were carried over Canadian wire services throughout the Dominion.

Radio stations in the Detroit area displayed their interest in the meeting by sending representatives to the press dinner, and by carrying stories on the Session over their regular newscasts.

A special vote of thanks is due Jack Pickering, *Detroit Times;* Robert Goldman, *Detroit Free Press;* Ray Baker, *Booth Newspapers;* and A. M. Smith, *Detroit News;* as well as to Art Everett, *Associated Press,* all for their efforts in making this MSMS Annual Session of interest to the people of Michigan.

WHAT THEY THOUGHT OF THE 1948 MSMS ANNUAL SESSION

F. H. Adler, M.D., Philadelphia (Guest Essayist): "I had a very pleasant time in Detroit and found very appreciative audiences. It was extremely nice to see so many of my old friends and I only regret that I did not have more time to spend with them."

* * *

Daniel Blain, M.D., Washington, D. C. (Guest Essayist): "I enjoyed the Michigan State Medical Society Annual Session more than I can tell you. My appreciation for being invited to participate. I would like to commend the Society on its inauguration, perhaps not new but certainly new to me, of the 'ubiquitous host' plan. I was royally entertained and I also wish to express my thanks to Dr. R. W. Cavell for his actions and the performance of his functions."

* * *

C. C. Burlingame, M.D., Hartford, Connecticut (Guest Essayist): "May I take this opportunity to commend you and your organization for your splendid planning of this meeting. Seldom have I been made to feel so welcome."

* * *

Stuart C. Cullen, M.D., Iowa City, Iowa (Guest Essayist): "I take this opportunity to express my sincere appreciation of the privilege of participating in the program of the Michigan State Medical Society. I have been to a number of State and National meetings of various organizations, and the hospitality your Society accords its speakers is matched only by the traditional South American hospitality that I encountered in Buenos Aires last October. I compliment you on a very well-run meeting and an excellent program."

* * *

M. Edward Davis, M.D., Chicago (Guest Essayist): "I enjoyed meeting many of my old friends and making new ones at the Michigan State Medical Society meeting. Please thank the officers of your Society for my invitation to participate in your excellent program."

* * *

Lester R. Dragstedt, M.D., Chicago (Guest Essayist): "My visit to the meeting of the Michigan State Medical Society was most enjoyable as well as profitable from the scientific point of view. You have a wide-awake, energetic organization, and I was very happy to have had a part in the program."

* * *

Haven Emerson, M.D., New York City (Guest Essayist): "Let me acknowledge the courtesy of your note, signed also by Secretary Foster, welcoming me to your meeting in Detroit. I enjoyed renewal of friendship with the many members I met, and I trust some benefit to others came from such contributions as I could make to the program. The friendly attentions of your 'ubiquitous host,' Dr. Molner, were much appreciated and made my day among you memorable to me."

* * *

M. Digby Leigh, M.D., Vancouver, B. C., Canada (Guest Essayist): "Thank you for the splendid reception which I have received by the Michigan State Medical Society. My ubiquitous host, A. B. Stearns, M.D., was indeed ubiquitous, congenial, and attentive at all times. May I commend the Michigan State Medical Society for its excellent organization and efficiency, which was most impressive. It might well serve as a pattern for many other medical organizations."

* * *

Walter L. Palmer, M.D., Chicago (Guest Essayist): "Thank you ever so much for the splendid care your group took of me in Detroit. I enjoyed the meeting greatly."

* * *

D. M. Pillsbury, M.D., Philadelphia (Guest Essayist): "The Michigan State Medical Society certainly is tops in hospitality. Mrs. Pillsbury and I enjoyed ourselves thoroughly."

* * *

Gerald H. Pratt, M.D., N.Y.C. (Guest Essayist): "I have been at four state medical society meetings this year and if the hospitality shown me in the other three were put together, it would not approach half of what has been shown to me while a guest of the Michigan State Medical Society. It was a great pleasure for me to be in Detroit at your Annual Session and your Society honored me by asking me. Please convey my very best wishes to them."

* * *

Walter J. Reich, M.D., Chicago (Guest Essayist): "It was a pleasure to speak at your recent MSMS Annual Session. May I take this opportunity of congratulating you on the very fine job and the hospitality which was unsurpassed. Thanks for a swell time."

* * *

Stanley P. Reimann, M.D., Philadelphia (Guest Essayist): "I certainly enjoyed my stay at Detroit at the MSMS Annual Session and incidentally learned many things from the Session. I want to thank you for your courtesy and hospitality. I want to express appreciation for the very friendly and courteous reception which I received when I came to Detroit. I enjoyed the MSMS

(Continued on Page 1172)



Throughout the *formative* years . . .

From birth to at least the age of 14 years, investigators now agree children are susceptible to rickets, with scarcely diminished frequency.[1]

The critical periods of active skeletal growth are found in infancy and childhood, lasting through at least the years just preceding puberty.[2]

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MIXED CARBOHYDRATES
IN EASY-TO-USE LIQUID FORM
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Bottles of 16 fl. oz. Write for Formula Blanks

1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.
2. Stearns, G.: *Jour. Lancet*, 63:344, Nov., 1943.

(Continued from Page 1170)

annual meeting and a number of the papers which I heard were certainly excellent. Congratulations and good wishes."

* * *

E. A. Strecker, M.D., Philadelphia (1948 Biddle Orator): "I hardly know how to express my deep and sincere appreciation of the wonderful and gracious hospitality of the Michigan State Medical Society. It will live long and very pleasantly in the memories of both Mrs. Strecker and myself. We both had a swell time and obviously, under your fine leadership, the Society had a great meeting. Warm regards from Mrs. Strecker and myself to the many fine people we met in Michigan."

* * *

Philip Thorek, M.D., Chicago (Guest Essayist): "I would like to take this apportunity to tell you what a distinct honor it was to address such an enthusiastic audience as the Michigan State Medical Society in Detroit. It was an event that I shall never forget. Congratulations on the tremendous success of your MSMS meeting."

* * *

Waltman Walters, M.D., Mayo Clinic (Guest Essayist): "It was an honor to be invited to present a paper before the Michigan State Medical Society and I wish I could have remained at the meeting longer."

* * *

E. G. Waters, M.D., Jersey City, N. J. (Guest Essayist): "The standards set up by your 'ubiquitous host' were so far surpassed in actual performance by Doctor L. S. Eno that I most certainly am spoiled for the rest of my life. I believe the officers of your Society should know that he spared neither effort nor time to make my recent visit to the Michigan State Medical Society meeting a long-remembered occasion. His attentions to me and also the amazing attendance at the scientific sessions will not soon be forgotten."

* * *

Fletcher D. Woodward, M.D., Charlottesville, Va. (Guest Essayist): "I wish to thank you for the very nice time I had in Detroit. I assure you I was well taken care of. May I congratulate you on having such a fine organization."

* * *

Irving S. Wright, M.D., New York (Guest Essayist): "I wish to express my grateful appreciation to the Officers and Members of the Michigan State Medical Society for the great courtesy and hospitality during my recent very brief visit. Dr. R. J. Schneck was a perfect ubiquitous host."

* * *

Lyle Hutton, M.D., Brantford, Ontario, Canada (Guest): "May I express to you my thanks for the hospitality accorded me as a guest at the Annual Session of your Society. It was one of the best meetings I have ever attended and in my opinion the organization of the meeting was faultless. I enjoyed the papers so much that I would like to have reprints if they are available."

* * *

Lawrence Hooey, M.D., Sudbury, Ontario (Guest): "Have enjoyed the Michigan State Medical Society meeting very much and I want to thank you for the privilege of us outsiders being able to attend these constructive postgraduate conferences. I wish to subscribe to THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY."

* * *

Frances Levy, M.D., Hamilton, Ontario (Guest): "I would like to take this opportunity of saying how much my husband and I enjoyed the Michigan State Medical Society Convention. It was really the best one I have ever attended and the most profitable from the academic standpoint. We are looking forward to your 84th Annual Session."

* * *

Mrs. T. Grover Amos, Detroit, President Woman's Auxiliary, 1947-48: "This year's association with the Michigan State Medical Society has been most enjoyable and I wish to thank you and the other Officers for everything!"

* * *

Homer D. Strong, Head of Alumni Affairs, Wayne University, Detroit: "I am constantly amazed at the smoothness with which you are able to arrange such a large convention. I know a little about the thousand and one details that go into the planning of such a program and I certainly congratulate you on such a successful convention."

* * *

Harold F. Alexander of Burroughs Wellcome & Co. (Exhibitor): "Have just received some enthusiastic reports from our representatives who attended our exhibit at your recent MSMS meeting. However, this does not surprise me as Michigan seems to have nothing but highly successful medical shows."

* * *

M. C. Bentley, Brooks Appliance Co. (Exhibitor): "The results of the meeting of the Michigan State Medical Society in Detroit last September were very satisfactory, as usual. We certainly hope to be with you in Grand Rapids next year. Many thanks for your interest and cooperation."

* * *

W. M. Monday of Hoffmann-La Roche, Inc. (Exhibitor): "All I can say is that we were kept busy every minute of the day. In our opinion, this was one of the best Michigan State Medical Society meetings ever held."

* * *

Morton Hack of Hack Shoe Company, Detroit (Exhibitor): "May we congratulate you on the unusually smooth running of the recent Michigan state meeting. There was none of the confusion usually evident at medical conventions. The setup was very well handled by your organization and it was our pleasure to be present."

* * *

Edna Mae McIntosh, Gerber's Products Company (Exhibitor): "The recent meeting in Detroit lived up to the usual standards typifying all of the meetings sponsored by the Michigan State Medical Society. The friendly and

(Continued on Page 1174)

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ESTINYL* (ethinyl estradiol) affords "relief of menopausal symptoms with excellent results"[1] in from 87.8 to 100 per cent[2] of cases. On a weight basis, ESTINYL is many times more powerful in estrogenic effect than other natural and synthetic estrogenic agents.[3] It acts rapidly, causing disappearance of hot flushes in 3 to 8 days[4] and often completely controls other climacteric symptoms in 7 to 10 days.[5]

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is well tolerated, there usually being "complete absence of side reactions if minimal effective doses are administered."[2] An additional asset of ESTINYL therapy is the "sense of well-being"[6] it commonly evokes.

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BIBLIOGRAPHY: 1. United States Dispensatory, ed. 24. Philadelphia, J. B. Lippincott Company, 1947, p. 1446. 2. Wiesbader, H., and Filler, W.: Am. J. Obst. & Gynec. **51**:75, 1946. 3. Allen, W. M.: South. M. J. **37**:270, 1944. 4. Lyon, R. A.: Am. J. Obst. & Gynec. **47**:532, 1944. 5. Groper, M. J., and Biskind, G. R.: J. Clin. Endocrinol. **2**:703, 1942. 6. Soule, S. D.: Am. J. Obst. & Gynec. **45**:315, 1943.

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absorption

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(Continued from Page 1172)

interested attitude of the Michigan physicians is now a legend among your exhibitors. I want to particularly mention the effectiveness of the large jumbo type registration badges. A person even with 20-20 vision welcomes the opportunity of making a quick identity when confronted with several familiar faces. I am sure the physicians appreciated this easier way of identifying each other as much as the exhibitors did."

* * *

R. V. Oosting, Medical Arts Surgical Supply Company, Grand Rapids (Exhibitor): "In behalf of my organization I wish to thank you for a very successful convention of the Michigan State Medical Society. The attendance was tremendous and we made many important contacts. We know that the success was accomplished only by the untiring efforts of you and your staff. Yours for many more successful meetings."

* * *

Stewart Cowell, Detroit, of J. T. Baker Chemical Company: "Let me congratulate you on the success of the meeting just closed. It was the best I can remember and I know that Dad (H. J. Cowell of Lea & Febiger, Philadelphia) shares this opinion."

* * *

Steven K. Herlitz, New York City, Medical Journals and Exhibits: "From my observations your MSMS meeting must have been a tremendous success and you are indeed to be congratulated on your achievement of bringing about such excellent doctor-exhibitor relationship."

FIFTY YEAR CLUB

"They serve God well who serve his creatures."—If you believe in this saying you will agree that the eleven new members of the Michigan State Medical Society's "Fifty Year Club" have reason to be proud of their half century of service to their fellow men.

Their awards, in recognition of fifty years of practice, were presented by President P. L. Ledwidge, M.D., on September 22 at the 83rd Annual Session and Postgraduate Conference in Detroit.

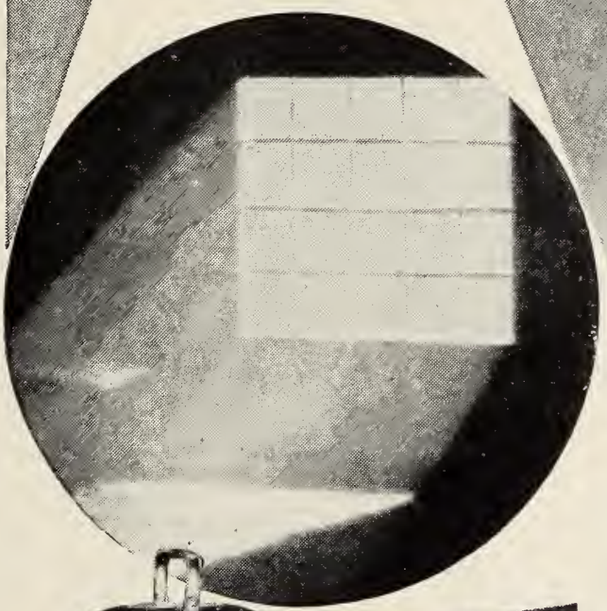
Those receiving the awards were:

Noah E. Aronstam, M.D., Detroit
C. M. Baskerville, M.D., Mt. Pleasant
H. B. Britton, M.D., Ypsilanti
Duncan A. Campbell, M.D., Detroit
G. H. Frace, M.D., St. Johns
J. R. W. Kirton, M.D., Calumet
Herbert W. Landon, M.D., Monroe
A. Leenhouts, M.D., Holland
Simeon LeRoy, M.D., Grand Rapids
John B. Morton, M.D., Detroit
Thomas Van Urk, M.D., Kalamazoo

The membership of the Fifty Year Club, which was founded in 1947, now totals 108 members.

Say you saw it in the Journal of the Michigan State Medical Society

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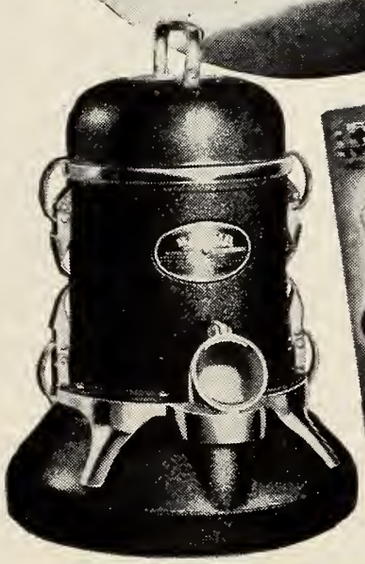


Next time you house-clean, pause a moment by a sunlit window. You will see thousands of dust motes floating in the beam.

Light does not produce this dust. It is everywhere in the air you breathe. Conventional methods of cleaning often fail to eliminate it, by letting dust filter back into the air you breathe.

Wouldn't you like to clean *clean?* Wouldn't you like to know that the dust you remove from floors, carpets and furniture is eliminated from your house forever? You can—with Rexair.

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HIGHLIGHTS OF THE COUNCIL SESSION

September 19, 20, 24, 1948

• Monthly financial reports and bills payable were presented, studied, and approved.

• Final report on proposed revision of MSMS Constitution and By-Laws was presented by Committee Chairman T. K. Gruber, M.D., Eloise, and referred to the House of Delegates for consideration at its September 20 meeting.

• Proposed Michigan Heart Association was endorsed after report by special committee of The Council composed of W. B. Cooksey, M.D., Detroit, Chairman; L. Fernald Foster, M.D., Bay City; H. H. Riecker, M.D., Ann Arbor; Frank Van Schoick, M.D., Jackson, and F. Janney Smith, M.D., Detroit. "We believe an affiliate of the American Heart Association in Michigan could extend to other fields of cardiovascular disease the very same pattern of helpfulness as emphasized in the Michigan Rheumatic Fever Control Program" read the Committee report.

The Committee on Organization of Michigan Heart Association was authorized to continue its work.

• Leon De Vel, M.D., Grand Rapids, was appointed full-time Co-ordinator of the Michigan Rheumatic Fever Control Program; his services begin on January 1, 1949.

• National Foundation for Infantile Paralysis representatives Joe W. Savage and H. E. Van Riper, M.D., New York City, and Donald W. Barton, Detroit, presented their findings on federated fund raising. The Council recommended that the Foundation request both the Michigan State Medical Society and its component county medical societies to appoint medical advisory committees, in order to obtain the full co-operation of the medical profession for the National Foundation for Infantile Paralysis; this suggestion met with the favor of the Foundation's representatives.

• Reports were accepted re meeting of the Ubiquitous Hosts held on September 8; Beaumont Memorial Committee re Beaumont Shrine at Mackinac Island; Public Relations Committee meeting of August 22; and the Permanent Conference Committee meeting of September 15.

• Report on Second Michigan Rural Health Conference of September 16-17, 1948—a highly successful meeting of rural folks interested in health—was presented by Public Relations Counsel Hugh W. Brenneman.

• The Supplemental Report of The Council was drafted and referred to the House of Delegates on September 20.

• National Physicians Committee. C. E. Umphrey, M.D., Detroit, reported on the recent NPC Conference in Chicago and requested co-operation of Michigan physicians in this activity.

• R. L. Novy, M.D., Detroit, was nominated to the Board of Michigan Hospital Service, to take the place of Wilfrid Haughey, M.D., Battle Creek, resigned.

• University of Michigan-Kellogg Foundation plan whereby a general practice resident would be assigned to a Traverse City hospital and also to the Mesick (Michigan) Health Center, as part of U. of M. training course for residents, was discussed and referred to the County Societies Committee.

• Proceeds of Grace W. Biddle Estate, when received from the Detroit Trust Company, are to be transferred to the Michigan Foundation for Medical and Health Education, to accomplish the purposes of postgraduate medical education as devised in the wills of the late Dr. and Mrs. A. P. Biddle.

• MSMS Representatives to the Governor's Conference on Youth, scheduled for Lansing, November 12-13, were appointed, at the invitation of Governor Kim Sigler: J. F. Harrold, M.D., E. J. Robson, M.D., and J. F. Sunder, M.D., all of Lansing.

• The Council (upon reference from the House of Delegates) adopted a motion that the 17th and 18th Councilor Districts be added from Wayne County, the term of the Councilor from the 17th District to expire in 1953, and the term of the Councilor from the 18th District to expire in 1949; The Council recommended that nominations for the two new Councilors be made by the Wayne County Delegation and that Wayne County be authorized to make decisions re boundary lines, when it wishes.

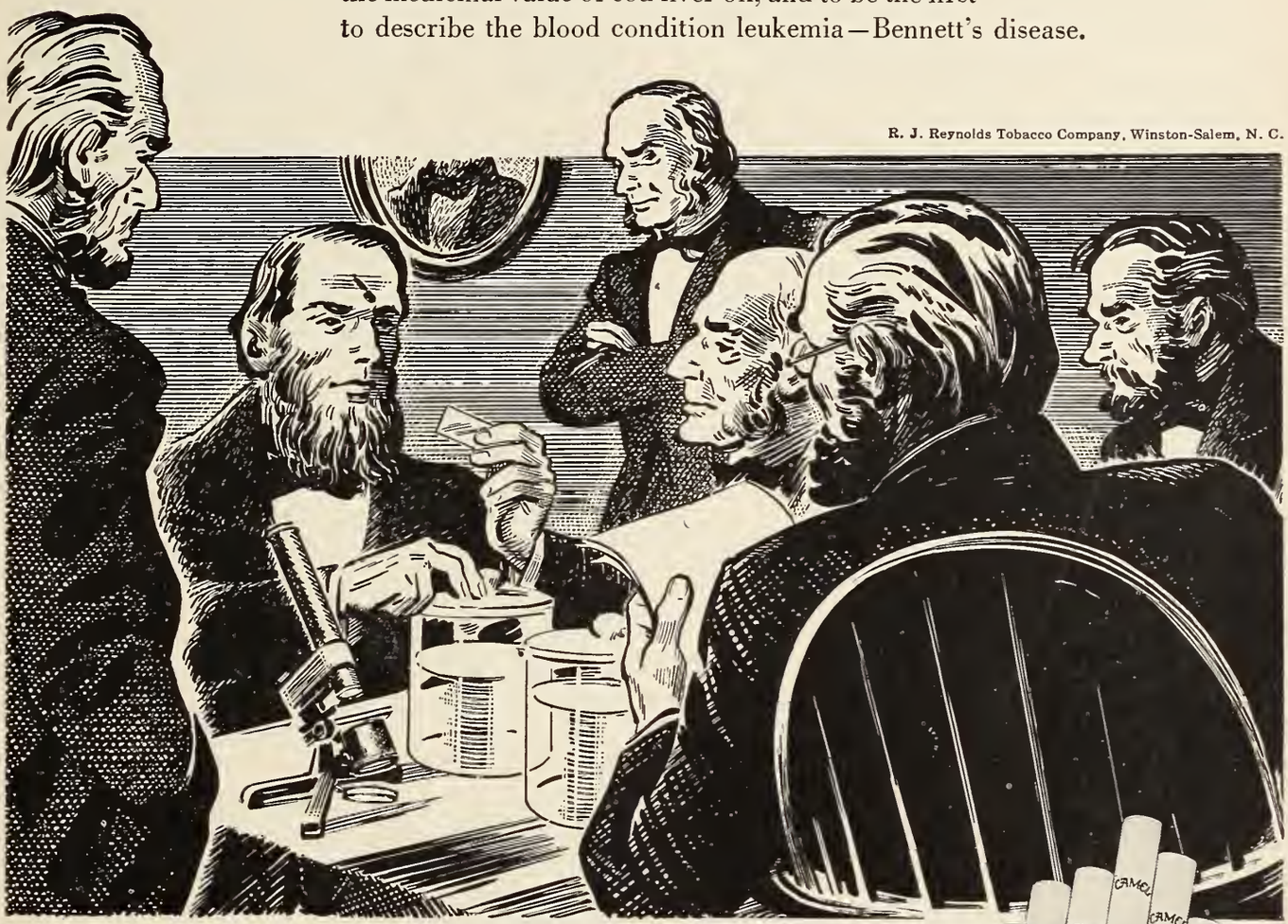
(Continued on Page 1178)

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In a nationwide survey by three independent research organizations, 113,597 doctors were asked to name the cigarette they smoked. More doctors named Camel than any other brand.

HIGHLIGHTS OF THE COUNCIL SESSION

(Continued from Page 1176)

• New Councilors were introduced at the September 24 meeting: W. B. Harm, M.D., and William Brommc, M.D., Detroit, 17th and 18th Districts; C. A. Paukstis, M.D., Ludington, 11th District, W. S. Jones, M.D., Menominee, 13th District, and L. C. Harvie, M.D., Saginaw, 8th District.

• Reorganization of The Council: O. O. Beck, M.D., Birmingham, was re-elected as Chairman; R. J. Hubbell, M.D., Kalamazoo, was chosen as Vice Chairman; C. E. Umphrey, M.D., Detroit, was elected as Chairman of the Finance Committee; F. H. Drummond, M.D., Kawkawlin, re-elected Chairman of the Publication Committee, and J. Duane Miller, M.D., Grand Rapids, re-elected Chairman of the County Societies Committee.

• Special Committees of The Council were announced by Chairman Beck and approved by The Council.

• Chairmen of MSMS Committees, as appointed by President Sladek, were announced and approved by The Council.

• An over-all plan for immunization was discussed with State Health Commissioner A. E. Heustis, M.D., who inquired if it might be possible for Michigan Medical Service to assume the cost of immunization procedures; this question was referred to the Board of Michigan Medical Service for consideration.

• Michigan's Attorney General's Opinion (No. 536), to the effect that boards of supervisors can make counties liable for welfare care, was presented and discussed by General Counsel J. Joseph Herbert.

• The Mediation Committee, a new subcommittee of the MSMS Public Relations Committee, presented a plan of action to bring information to county medical societies. The Council urged that county and district societies arrange meetings in the very near future to hear the important report of the PRC Mediation Committee.

• Michigan Health Council is to be informed that the $7,500 allocation from MSMS, approved in the January, 1948 budget, is still available for the purposes of the Michigan Health Council.

• The Council placed on its minutes an official vote of thanks to all who helped make the 1948 MSMS Annual Session a great success. Executive Secretary Burns reported that the total registration was an all-time high—3,399, of which 2,751 were doctors of medicine.

AMERICAN ACADEMY OF GENERAL PRACTICE

Eighteen outstanding medical teachers have been selected by the Program Committee for the first Annual Scientific Assembly of the American Academy of General Practice to be held in Cincinnati, at the Netherlands Plaza Hotel, March 7, 8, and 9, 1949. The names of the essayists and their subjects will be announced later.

On September 15, the Executive Committee of the Board of Directors, composed of President Paul A. Davis, Akron, Dr. E. C. Texter, Detroit, and Dr. U. R. Bryner, Salt Lake City, met with the Program Committee and the members of all special committees concerned with preparations for the Assembly in Cincinnati to go over all preliminary details for the meeting. Doctors Davis and Texter are co-chairmen of the Program Committee. Other members are Dr. F. G. Benn, Minneapolis, Dr. R. C. McElvain, St. Louis, and Dr. J. P. Sanders, vice president, of Shreveport, Louisiana.

All members of the Committee on Local Arrangements were present. Dr. Joseph Lindner, Cincinnati, is chairman of the Committee on Local Arrangements. He has appointed Dr. Arthur N. Jay, Cincinnati, to be chairman of the Sub-Committee on Registration.

Dr. E. Clarkson Long, Detroit, is chairman of the Committee on Technical Exhibits. Indications are that the leading pharmaceutical and equipment manufacturers of the country will be represented in the technical exhibit.

Mrs. Joseph Lindner, Cincinnati, is chairman of the Ladies Entertainment Committee. A separate registration desk and a hospitality desk will be maintained for the ladies and a series of pleasant social functions are being planned for them.

The Assembly will open at 9:00 a.m. on Monday, March 7, with an invocation and greetings from representatives of the mayor of Cincinnati and the local medical society. The opening general session will be closed with the Presidential Address of Dr. Paul A. Davis. The first scientific paper will be presented at 9:30 a.m. in the Hall of Mirrors.

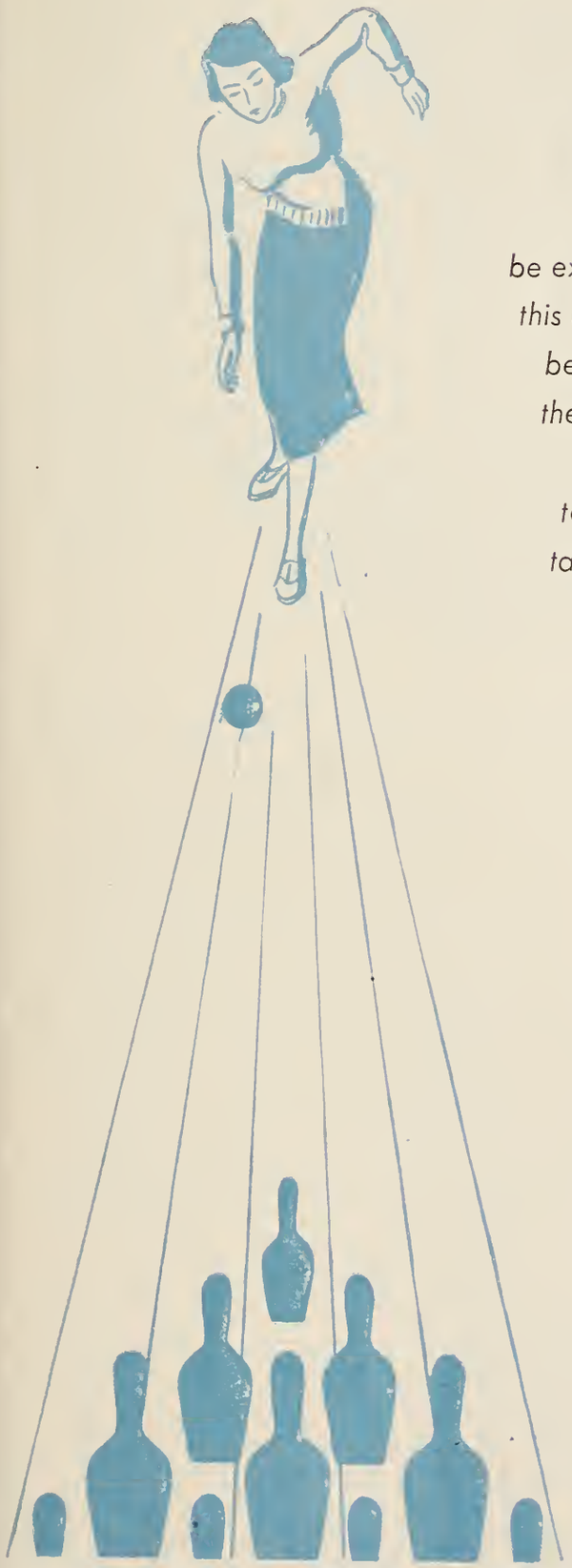
On Monday evening there will be a dinner for secretaries and presidents of constituent state chapters. The annual banquet for all members, their wives and friends, will be held on Tuesday evening. The meeting will close at noon on Wednesday, March 9.

The Congress of Delegates will meet at 10:00 a.m. on Sunday, March 6, preceding the Assembly and again, for its second session, on Tuesday afternoon.

Arrangements have been made to accommodate more than 2,000 members and their wives. Non-members of the Academy may attend the Assembly as guests on payment of a registration fee of $5.00. Only Doctors of Medicine may register. There will be no registration fee

(Continued on Page 1180)

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*The physical and emotional distress caused by hot flushes, nervous spells and other symptoms may completely alter the personality and life pattern of the woman at the climacteric. Clinical experience has shown that, in the majority of cases, prompt remission of disturbing symptoms can be expected following the use of "**Premarin.**" In addition, this natural oral estrogen usually imparts "a sense of well-being"...the plus in "**Premarin**" therapy which enables the patient to resume an active and enjoyable existence. Three potencies of "**Premarin**" permit the physician to adapt therapy to the particular needs of the patient: tablets of 2.5 mg., 1.25 mg., and 0.625 mg., also liquid containing 0.625 mg. in each 4 cc. (1 teaspoonful). While sodium estrone sulfate is the principal estrogen in "**Premarin,**" other equine estrogens ...estradiol, equilin, equilenin, hippulin...are probably also present in varying amounts as water soluble conjugates.*

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AMERICAN ACADEMY OF GENERAL PRACTICE

(Continued from Page 1178)

for members. Banquet tickets will be sold at $5.00 per plate.

A printed form for requesting hotel accommodations will be sent to all members later. Members wishing to make reservations now may do so by addressing the Chairman, Sub-committee on Hotels, American Academy of General Practice, Dixie Terminal Building, Cincinnati 2, Ohio.

"SECURITY" WILL BE BACKBREAKING LOAD

From time to time over the last five years this column has made use of private and official "vital statistics" to illustrate the economic pitfalls of cradle-to-grave security in a relatively free competitive system. In every instance the figures have tended to bolster the conviction of social security's critics that traditional American enterprise and government insurance against normal hazards are fundamentally incompatible.

Recently we've had some testimony on this subject from an unexpected source, the Federal Security Agency. FSA experts took a look at death rates in this country and came up with data showing life expectancy today to be greater by about 24 months than it was a brief seven years ago.

What FSA's findings boil down to is this: The average American born in 1948 can expect to be here in 2015, regardless of sex or race. In contrast, life expectancy in 1939-1941 was 65 years, and in 1933, barely 60 years. The average individual born in 1875 could expect to live only 42 years. The figures are even more interesting when broken down for sex and race. For white U. S. females born in 1948, expectancy is 70.3 years; 60.1 years for nonwhite females. The white male can hope for 60.1 years on the average; the nonwhite male 57.5 years.—Insurance Economic Surveys, September, 1948.

TONSILLECTOMY AND POLIOMYELITIS

John W. Eschenbrenner, M.D., in his article in the *Texas Medical Journal* for July, 1948, says:

"Statistics were presented by Roberts in 1946, noting that 274 cases of poliomyelitis following recent tonsillectomy have been reported during the past thirty-five years. From figures of the United States Public Health Service, it is estimated that 70,000,000 tonsillectomies were done during this period. It is estimated that 75 per cent of this number were done on patients under 18 years of age. Half of these, 24,000,000 were performed during the poliomyelitis months. This would give an incidence of 1 case of poliomyelitis to approximately 100,000 recent tonsillectomies. The average annual incidence of poliomyelitis in everyday life is 1 to 3,250 of population, which is 31 times greater than in the recently tonsillectomized population even during the poliomyelitis season. . . .

"Pederson in 1947 reported a study of the poliomyelitis cases admitted to the San Francisco City and County Hospital and the San Francisco Children's Hospital for the period from 1941 to 1945, inclusive. He tabulated answers to a form letter sent to the hospitals in the counties in which the poliomyelitis cases had originated concerning the number of tonsillectomies done in that period. He found that the incidence of poliomyelitis to general population in an epidemic year (1943) was 1 to 1,960 while the incidence of poliomyelitis following tonsillectomy for the same period was 1 to 1,782. He also concluded that the incidence of poliomyelitis following recent tonsillectomy is not greatly out of proportion to the ratio of disease to the general population during an epidemic year. When poliomyelitis occurs following a tonsillectomy it is more apt to be bulbar in form. There is a higher incidence of bulbar and bulbospinal type poliomyelitis in tonsillectomized patients than in non-tonsillectomized patients, the ratio being 2 to 1. . . .

"Probably the most comprehensive study of the problem has been done by Cummings of New York. He started out in extending the survey of Page on the incidence of poliomyelitis following tonsillectomies performed at the Manhattan Eye, Ear and Throat Hospital. This study of 11,204 tonsillectomy patients over a seven-year period revealed but 4 cases of poliomyelitis following tonsillectomy, none being of the bulbar type.

"It has been established that the oxygen requirement of the central nervous system is approximately 30 times that of other tissues of the body. Anesthesia, through the production of anoxia, might in itself be sufficient cause for disturbance of the host-virus relationship and capable of precipitating severe attacks of infantile paralysis."

MENINGITIS LOSING ITS STING, ARMY REPORTS

Spinal meningitis, terror of World War I training camps, has today lost much of its menace, according to a report by Dr. Worth B. Daniels submitted through the Office of The Surgeon General of the Army and published in the *Archives of Internal Medicine.*

The report points out that less than three per cent died of some 14,500 soldiers treated during the World War II period for this once almost hopeless infection. The remarkably low death rate was due, Dr. Daniels said, both to the efficacy of sulfadiazine and penicillin in controlling the infection and to quicker diagnosis. Early diagnosis and the prompt use of the drugs can usually stop the spread of the bacteria before they have a chance to become localized in the linings of spinal cord and brain.

Altogether there were about 300 deaths from meningococcic infection in World War II. Approximately 10 per cent of these died before the germ had become localized in the nervous system tissues.

The war experience, Dr. Daniels says, shows that sulfadiazine is the best available drug. It is not as effective as penicillin against the bacteria in the blood stream but the latter drug proved to have one great disadvantage. While penicillin circulates through the blood stream freely, it does not get into the cerebro-spinal fluid in predictable quantities and hence cannot be relied upon to prevent invasion of brain and spinal cord tissues. Sulfadiazine enters the spinal fluid rapidly in high concentrations.

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Merck research has been directly responsible for many important contributions to the synthesis, development, and large-scale production of individual vitamin factors in pure form.

In a number of instances, the pure vitamins may be considered to be products of Merck research. Several were originally synthesized in The Merck Research Laboratories, and others have been synthesized by Merck chemists and collaborators in associated laboratories.

Merck experience in the production of vitamins extends from the time of the original synthesis of the first pure vitamin, down through the recent isolation of Vitamin B_{12} in The Merck Research Laboratories.

Because most of the known vitamins have now been made available in pure form, effective therapy of specific vitamin deficiencies can be conducted on a rational and controlled basis, under the direction of the physician.

MERCK VITAMINS

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Manufacturing Chemists

Michigan Medical Service

MMS-MHS HAS TWENTY DISTRICT OFFICES

Within a comparatively few miles of every Blue Cross-Blue Shield participating doctor in Michigan there is a Blue Cross-Blue Shield district office operated for the purpose of being of service to doctors, hospitals and Blue Cross subscribers in local areas.

Twenty district offices, located strategically throughout the state, have been established by Michigan Medical Service—Michigan Hospital Service for the purpose of enrolling groups, distributing information, answering questions, clarifying misunderstandings and explanation of certificate benefits.

Listed in most of the state's telephone directories under Michigan Medical Service and Michigan Hospital Service or classified under Blue Cross Plans, the offices are located in these twenty cities and serve the counties following:

Ironwood—Gogebic, Ontonagon, Keweenaw, Houghton, Baraga, Iron and Dickinson.
Marquette—Marquette, Menominee, Alger, Delta, Schoolcraft, Luce, Chippewa and Mackinac.
Alpena—Alpena, Alcona, Oscoda, Montmorency, Presque Isle, Cheboygan and Otsego.
Traverse City—Emmet, Charlevoix, Antrim, Leelanau, Benzie, Manistee, Grand Traverse, Kalkaska and Crawford.
Mt. Pleasant—Wexford, Missaukee, Roscommon, Ogemaw, Osceola, Clare, Gladwin, Mecosta, Isabella, Montcalm and Gratiot.
Muskegon—Mason, Lake, Oceana, Newago and Muskegon.
Bay City—Arenac, Bay, Iosco, Midland, northeast Tuscola and western half of Huron.
Saginaw—Saginaw and southwest Lapeer.
Flint—Shiawassee, Genesee and Lapeer.
Port Huron—Eastern half of Huron, Sanilac and St. Clair.
Pontiac—Oakland and Macomb.
Ann Arbor—Livingston and Washtenaw.
Lansing—Clinton, Eaton, Ingham and Portland in Ionia.
Jackson—Jackson.
Battle Creek—Calhoun and Barry (except Hastings).
Kalamazoo—Kalamazoo.
Hillsdale—St. Joseph, Branch, Hillsdale and Lenawee.
Benton Harbor—Van Buren, Cass and Berrien.
Holland—Ottawa and Allegan.
Grand Rapids—Kent, Ionia, and Hastings in Barry.

PUBLIC EDUCATION MESSAGES TELL BLUE CROSS STORY

Recognizing the need for retelling the story of Blue Cross, Michigan Medical Service and Michigan Hospital Service recently sponsored a series of four public education messages in the daily and weekly newspapers of Michigan.

As an introduction to the main campaign a joint annual statement of condition of the two organizations was published. This statement did not follow the usual pattern of financial statements in that it dramatized the fact that Michigan Hospital Service and Michigan Medical Service were currently paying more than one and one-half million dollars a month for care-rendered Blue Cross subscribers in Michigan. In addition, a column of space was used to tell the story of the origin and growth of the Plans since inception.

Following the release of the annual statement a series of three institutional messages were published at one-month intervals. The first in this series sounded the keynote of the campaign—"The Way of Democracy." The text of the message pointed out that the way of democracy was man's finest achievement and the American way was one of voluntary group action born of freedom of enterprise. An illustration of Lincoln dominated the space to emphasize the democracy theme.

The second release in this series was a natural development of the central theme with copy pointed to the fact that the voluntary system of pre-paid health care, as epitomized in Blue Cross, was simply "Democracy In Action"—voluntary action through group and individual initiative to solve an economic problem without the aid of governmental control.

The third, and last of this series, brought the point more closely home by using the "Pattern Of Democracy" as being the guide for the development of Michigan Medical Service and Michigan Hospital Service. Once again the illustration dramatized freedom of action as the American way to solve social, community and economic problems.

More than 100 publications in Michigan carried this series of releases, including farm journals and labor papers as well as the daily and weekly newspapers. The number of messages printed totaled more than 8 million.

The effectiveness of this campaign was recognized immediately. Reports from Michigan Medical Service and Michigan Hospital Service field representatives indicated that they were receiving a more favorable reception when calling on prospective groups for enrollment in the Plans as well as a strengthening of existing groups. More significant, however, were the many hundreds of letters and inquiries received from readers asking how they too might join in the Blue Cross program. The impact of this campaign on the political scene is evidenced by the following letter received by Mr. Burns at the Society's headquarters from Senator Arthur Vandenburg: "I believe this is a splendid development in your Blue Cross program. You have 'hidden your light under a bushel' far too long. You have a proud story to tell and the public needs to know it. This is the practical way to checkmate all-out 'socialized medicine.' I congratulate you upon what you are doing."

(Continued on Page 1186)

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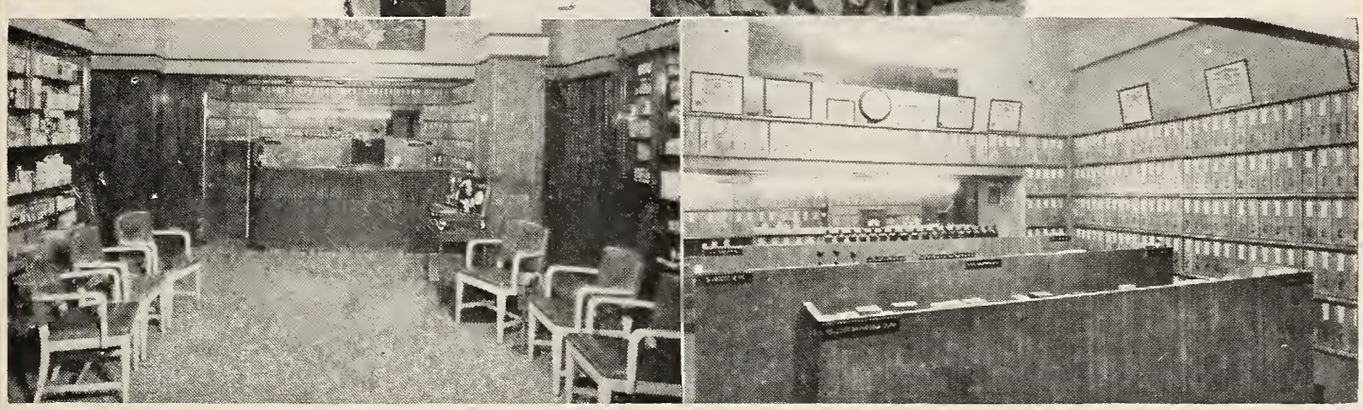




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PR in Practice

Attendance Record Broken at Michigan Rural Health Conference

The second annual Michigan Rural Health Conference was attended by a record-breaking group of 462 people interested in the problems of rural health.

This attendance was due in a large part to the thousands of inches of favorable publicity given through news releases, feature stories, and notices to the members of ancillary organizations through intra-organizational papers, bulletins, magazines, et cetera.

The Conference, sponsored by the Michigan State Medical Society and co-sponsored by forty other interested organizations, was held on the campus of Michigan State College, September 16-17, for the purpose of stimulating the groups interested in rural health to co-ordinate their activities and to gain with the people of rural Michigan an enthusiastic accord and plan for constructive action.

The procedure for the Conference was as follows: On the opening afternoon following the four principal talks delivered by Howard Y. McCluskey, Ph.D., LL.D., Ann Arbor; A. E. Heustis, M.D., Lansing; Miss Ruth Parsons, Fowlerville; and General Paul R. Hawley, Chicago, the Conference divided into four section meetings on the topics: (1) "Planning for Healthy Communities," (2) "Modern Medicine in Rural Michigan," (3) "Youth in the March of Health," (4) "Dollars and Disease." Each of these sections was further divided into four groups and sixteen groups to allow for a wider range of discussion and segregation of subject material.

The evening meeting was climaxed by an address before the general assembly by United States Senator Homer Ferguson on "The Frameworks of Security."

On the following morning a panel consisting of the section and group leaders from each of the four sections and sixteen groups constituted the report of these bodies to the Conference as a whole. The meeting concluded with the business and resolutions of the Conference.

Letters are still being received from interested parties throughout the United States who would like a résumé of the work of the Conference, indicating that this yearly meeting aroused considerable interest among people who desire to improve health facilities.

The most important thing to come out of this year's Michigan Rural Health Conference was the fine spirit of co-operation displayed by those who attended the meeting and the grass roots demand for Community Health Councils. Everyone seemed to pull together, realizing that all are working toward the same goal—to keep Michigan "Leading the Way in Health Progress."

"Tell Me, Doctor" Program Has Sponsor

The J. F. Hartz Company, a Detroit pharmaceutical firm, has assumed sponsorship of the "Tell Me, Doctor" program, effective November 1, over radio station CKLW, Detroit. This program will be heard Monday through Friday at 10:45 a.m.

The program has been carried over station CKLW since its inception, for a time under the sponsorship of Borden's Farm Products of Michigan, and more recently on a sustaining basis.

The "Tell Me, Doctor" show is now being broadcast over twenty-three Michigan radio stations, as well as over forty stations in other states.

One Million to See "Lucky Junior"

The MSMS motion picture "Lucky Junior" is now being booked for showing in theaters throughout Michigan. More than 100 theaters have already scheduled it for release in the next three months.

It was originally estimated that approximately half a million people would see this film but due to the volume in which the bookings have been received, this figure has been revised upward to a million.

This estimated attendance was arrived at as follows: If bookings continue to come in at the present rate, 400 theaters will have scheduled the picture for an average showing of two and a half days, making a total of 1,000 days. As each theater runs between two and three shows a day, this will amount to approximately 2,500 projections. If the average size audience is conservative-

(Continued on Page 1186)

A TOP FAVORITE IN PROTEIN SUPPLEMENTATION

Caminoids

TRADEMARK

BRAND OF AMINOPEPTODRATE

For Oral Administration

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

IN NEW PACKAGE SIZES for GREATER CONVENIENCE and ECONOMY



Caminoids* is now supplied in cans containing 1 pound and 5 pounds, as well as in bottles containing 6 ounces. **CAMINOIDS** is derived by enzymic digestion of liver, beef muscle, wheat, soya, yeast, casein, and lactalbumin. It has high biological value, high palatability, and outstanding patient-acceptance.

DOSAGE: One tablespoonful of **CAMINOIDS** three times daily supplies 12 Gm. of protein as hydrolysate. Available at leading pharmacies.

*New designation of Aminoids adopted as a condition of acceptance by the Council on Pharmacy and Chemistry of the American Medical Association. The word CAMINOIDS is an exclusive trademark of The Arlington Chemical Co.

Arlington

THE ARLINGTON CHEMICAL COMPANY

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One Million to See "Lucky Junior"

(Continued from Page 1184)

ly estimated at 400, this will make a total audience of around one million persons.

These figures do not take into account the 16mm films which will be made for showing to individual groups after the 35mm print has appeared in the theaters of Michigan.

Numerous organizations throughout the nation have indicated their interest in this picture. Inquiries and favorable comments on the film have been received from the AMA, the Illinois, Virginia, and South Carolina State Medical Societies, and also from Parke-Davis Company, to name only a few.

Prepare "Medical Associates" Campaign

The Medical Associates brochure, outlining the opportunities open to young men and women in the ancillary fields of medical care, has been completed. It is now being distributed to high school, college, and university students, advisors, and administrators.

Despite the fact that this brochure has not been advertised or widely publicized as yet, requests from interested parties continue to pour in regarding the opportunities open as a Medical Associate.

A full-fleged campaign will open shortly in order to make this brochure familiar to young people throughout Michigan. Slides and transcriptions have been developed in order to present the concept of Medical Associates to young people in the public schools.

R. H. Pino, M.D., Detroit, Chairman of the Commission on Health Care, has enlisted the cooperation of the State Superintendent of Public Instruction in this project. In addition, Dr. Pino presented the plan before the Michigan College Association in Ypsilanti. Representatives from the majority of the colleges in Michigan have committed their institutions to carry the necessary courses in order that complete Medical Associate training will be available in Michigan. The hospitals have also agreed to co-operate in training these valuable health workers.

Individual doctors and county medical societies will be urged to work with the Woman's Auxiliary in each community in order to insure that the brochure is thoroughly explained to the Parent Teachers Associations and prominently displayed in school libraries and before student groups.

With the co-operation of each of these individuals and agencies there is no reason why the Medical Associates brochure should not be familiar to every young person in Michigan within a few months' time.

Woman's Auxiliary Brochure in Demand

The Woman's Auxiliary brochure has been completed and distributed. It contains PR material on such specific projects as the popularization of Health Month and Immunization Month, the promotion of Medical Associates, assisting the Blue Cross in their Community Enrollment drives, and others.

Numerous requests have been received from Woman's Auxiliaries of other State Medical Societies for copies of this brochure to be used as a model for their own Public Relations programs. Copies of the booklet have been sent to the secretaries of the County Medical Societies of Michigan.

All MSMS members should encourage the officers of their local Auxiliaries to activate the projects outlined in this brochure.

MICHIGAN MEDICAL SERVICE

(Continued from Page 1182)

OVER ONE MILLION

United Medical Service, the Doctors' Plan of New York on August 31, 1948, reported 1,006,201 persons protected by their plan. They have increased 275,908 in the first eight months of this year. This is a remarkable growth.

MICHIGAN HOSPITAL SERVICE

The Balance Sheet of August 31, 1948, showed an unallocated reserve of $1,169,101.28.

The Board has changed the basis of payment for participating hospitals to 100 per cent of charges or 102 per cent of cost, whichever is the lesser.

As of July 31, 1948, there were 1,306,805 persons covered by contracts in force. Blue Cross and Blue Shield Plans are holding joint and separate meetings at French Lick Springs, Indiana, October 25, 1948, through October 28, 1948, at which time the need for a joint Blue Cross-Blue Shield National Enrollment Corporation will be discussed. All members of the Board of Michigan Hospital Service and Michigan Medical Service who can, have been urged to attend this meeting.

WHY MANY LEADING NOSE AND THROAT SPECIALISTS SUGGEST

"change to PHILIP MORRIS"*

Where smoking is a factor in a throat condition, the physician may advise "Don't Smoke." But where the patient persists, many eminent specialists suggest "*Change to* PHILIP MORRIS"... the *one* cigarette proved definitely less irritating.** Perhaps you too will find it advantageous to suggest to your throat patients "*Change to* PHILIP MORRIS." For your own smoking as well, Doctor, in fact for *all* smokers, Philip Morris is by far the wisest choice.



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IF YOU SMOKE A PIPE... We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

**Completely documented evidence on file.*

***Reprints on Request:*

Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32,241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

Cancer Comment

PROFESSIONAL EDUCATION IN CANCER

Opportunities for professional education in the cancer control field are rapidly increasing. During the current year, regional meetings of several days each have been held in Louisville, Kentucky, Denver, Colorado, Sioux Falls, South Dakota, Madison, Wisconsin, and elsewhere in the midwestern area, as well as in other areas, each attended by large numbers of physicians tributary to that particular area.

Some of these programs consist of symposia on research problems related to cancer, some are entirely clinical in character, and some combine research and clinical discussions. An example of this last type of meeting was the three-day symposium held in Detroit in October, under the auspices of the Wayne County Medical Society and the Detroit Institute of Cancer Research. The first two days of this meeting were devoted to a consideration of the fundamental properties of protoplasm and the third day to a clinical discussion of several important types of cancer. This Detroit symposium drew an attendance of several hundred research workers and physicians from twenty-two states, Canada, and Mexico.

The United States Public Health Service and the American Cancer Society sponsor professional cancer meetings on the national level. State and local medical organizations throughout the country frequently provide excellent programs on some phase of the cancer problem. In Michigan, during the past year the Calhoun, Genessee, Kalamazoo, Kent and Wayne county medical societies have sponsored special cancer meetings on an all-day or afternoon and evening basis. Many other local medical organizations have had programs devoted partly or entirely to cancer subjects.

By means of appropriations from the United States Public Health Service, both medical schools in Michigan are organizing more intensive courses in cancer training for undergraduate medical students. A meeting of representatives of all participating medical schools was held recently in Chicago to discuss the scope and method of making this teaching plan effective.

The Michigan Plan of Postgraduate Medical Education is providing a four-day course in cancer at the University Hospital in January, 1947.

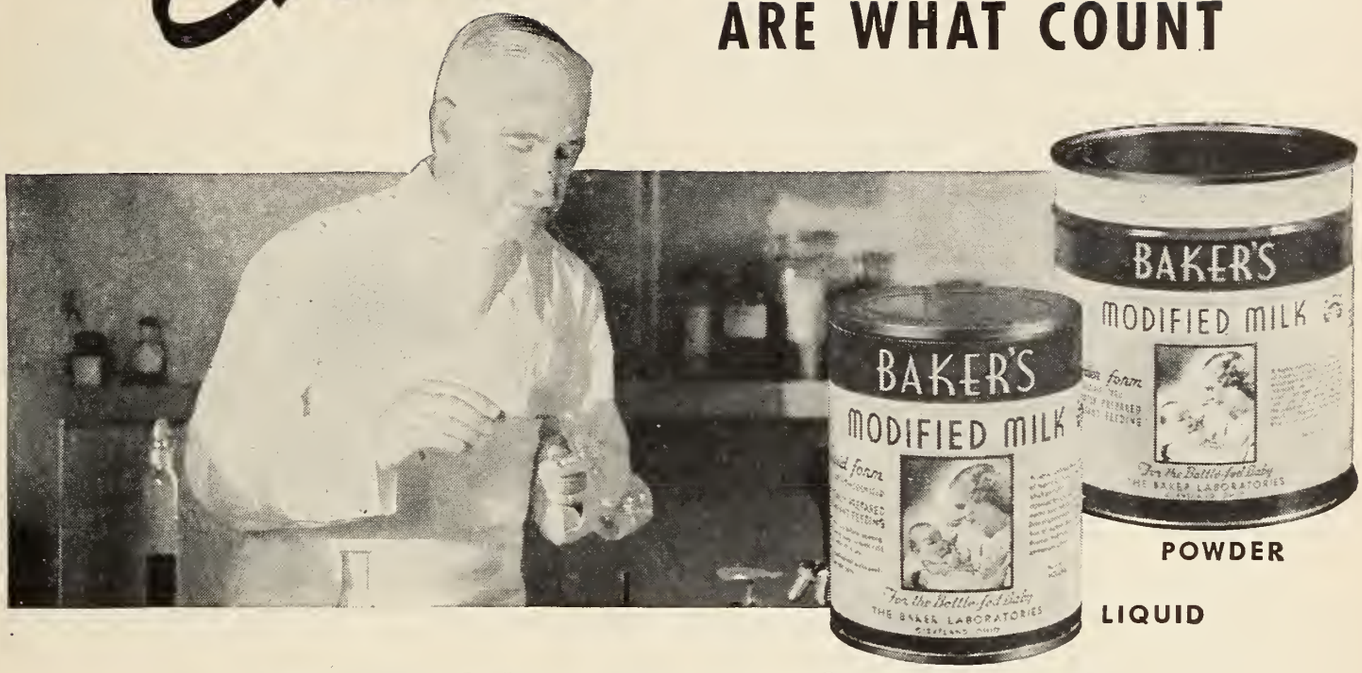
This increased interest in professional cancer education stems largely from the aroused lay interest in the subject of cancer control, which, in turn, is due to the increased activity of the American Cancer Society and other organizations interested in this field. The public is clamoring for increased service in the fields of diagnosis, treatment, and prevention; fields in which the physician must play a major role if the service is to be effective.

Through ill-advised publicity in lay magazines the public often is led to expect miracles from the medical profession in the diagnosis and treatment of cancer. In any social program that embraces so many emotional factors that can be called into play, such overemphasis is to be expected. This, however, does not excuse the disservice such journalistic activities render to the public.

While there are many commendable efforts being made for professional education in Michigan in the field of cancer control, they can and should be extended to larger segments of the population. There is an opportunity through the School of Public Health of the University of Michigan for a better understanding of the cancer problem by official health agencies and the part they should play in it. There is a need for more cancer programs in local medical society meetings. There is need for more medical co-operation in local cancer society programs and projects. Funds are increasingly available for national, state and local activities in the spending of which professional direction is sorely needed to insure their expenditure for the greatest good to the community.

Lay groups are asking for greater participation by physicians in their local programs. The opportunity is ripe for the direction of local cancer programs along lines of greatest service to the community and the cancer patient. If the significance of this opportunity is not grasped, the increasing funds available in this field may be utilized for services not in keeping with the best interests of the cancer patient. Each physician should carefully study his local cancer problems and the means proposed for their solution.

THE *End Results* ARE WHAT COUNT



Backed by Years of Research

BAKER'S MODIFIED MILK

Meets Doctors' Demands . . . Infants' Needs

● A complete milk diet that closely conforms to human milk . . . a nutritious food for infants that may be used either complemental to or entirely in place of human milk . . . well tolerated by both premature and full-term infants . . . a food that may be used from birth until the end of the bottle feeding period—without changing the formula . . . a diet that means a well-nourished, happy baby.

These are "end results" of the years of research back of Baker's Modified Milk.

What the attainment of these results means to doctors is attested by the steadily increasing use of Baker's Modified Milk, which is advertised only to the medical profession. More and more doctors are prescribing Baker's Modified Milk because they find Baker's produces desired results with less trouble in most cases of infant feeding . . . that no change in dilution is needed as the baby grows older (just increase the quantity of feeding) . . . and the possibility of errors—always present when formulas are prepared in the home—is avoided.

To prepare Baker's for feeding merely dilute it to the prescribed strength with water, previously boiled. Baker's is available in both powder and liquid forms. Formulas made from liquid Baker's are especially easy to prepare; in some cases, such as the lack of refrigeration in hot weather, or when traveling, the powder form is preferable.

Just leave instructions at the hospital. The obstetrical supervisor will be glad to put your next bottle-fed infant on Baker's Modified Milk.

● Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 800 units of vitamin D per quart.

ACCEPTED
COUNCIL ON FOODS AND NUTRITION
AMERICAN MEDICAL ASSOCIATION

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC., Cleveland, Ohio DIVISION OFFICES: SAN FRANCISCO, LOS ANGELES, DENVER, SEATTLE, and GREENSBORO, N.C.

Political Medicine

EWING HEALTH PLAN

In an interview to the press on September 2, President Truman supported the Ewing program, saying that he is compelled to advocate national health insurance because he sees no other possible way of bringing medical service to fully half the American people. Just how hard have President Truman and Oscar Ewing tried to see some other way? Just whom have they called upon to help them look?

Recently the general assembly of the World Medical Association met in Geneva with a considerable number of nations of the world represented. Had Mr. Ewing or President Truman been present—or even been represented by some one capable of evaluating the opinion of the physicians of the world about what compulsory sickness insurance has been doing to medical practice in other countries—they would be perhaps a little less certain on the point that compulsory sickness insurance is the answer to difficulties in securing medical care. The amount of medical care that is given to most people of the world under their compulsory sickness insurance plans would never satisfy the people of the United States. The inevitable faults of these systems, which have been emphasized to the American physicians and to the American people for a good many years, are now coming vividly to light. Great Britain embarked in its new National Health Act on July 5. People in England may now go to the doctor without calculating the cost of the service. They may be supplied with spectacles and teeth without additional costs. They may have consultants and beds in hospitals without reference to individual payments for services rendered. That is what the National Health Act of Great Britain promised them. Do you think that they get it? No, indeed! They queue up to see the doctors formerly they could have seen by appointment. The doctors write formulas and prescriptions and reports many hours in advance of the time when they see the patients because otherwise they would never have time to see the patients. Many a physician is already satisfied that he cannot work under the Act. The unfortunate public has no way of knowing whether or not what they get is good medical service or something to make them think that they are being given attention. The greatest folly in the world is the manner in which Great Britain embarked on a nationwide health service without hospitals, doctors, nurses, drugs or money to supply what they promised, and an even greater folly would be the attempt to offer a similar service in the United States and to gulp the entire medical problem of the nation in a single swallow. Should the United States accept the prescription by President Truman and his consultant, Mr. Ewing, it would likely discover that the prescription had little of curative value and a great deal of the ultimate effect of ipecac or apomorphine (these, Mr. Ewing, are classified by the books on drugs as emetics).—Editorial, JAMA., September 25, 1948.

A DOCTOR'S VIEW

I wish to congratulate you on your article in the *Detroit Free Press* under the heading of The Red Pill. This article expresses my feeling completely on socialized medicine. If we ever get socialized medicine, the politician will be the doctor; and God knows he cannot take care of his own ills, let alone the patient's ills.

In the first place there would not be enough doctors to take care of the needs of every individual if socialized medicine were forced upon us. There is a shortage of physicians today, and it is a fact that more people would come to doctors than ever before if Uncle Sam were paying the bill.

Socialized medicine means inferior practice of medicine, and we recognize that our practice of medicine is not perfect.

Let me again congratulate you on your article, and I hope that other editors will follow your course.

M. G. Wood, M.D., Hart,
Detroit Free Press

ONE OUT OF SIX ADULTS GETTING U. S. HANDOUTS

One adult American in six is now receiving money from the federal government. Uncle Sam distributes largesse regularly to 15,830,899 citizens, according to a United Press survey.

War veterans and their dependents comprise the largest single group; 6,526,505 of them are receiving federal aid —pensions, unemployment insurance, on-the-job training or schooling.

Other recipients are 2,086,000 federal employes, 1,412,000 servicemen, 2,471,000 social security beneficiaries, 3,205,131 farmers, 125,000 retired civil service employes.—Insurance Economic Surveys, September, 1948.

AMERICAN MEDICAL ASSOCIATION SECRETARY'S LETTER

September 27, 1948

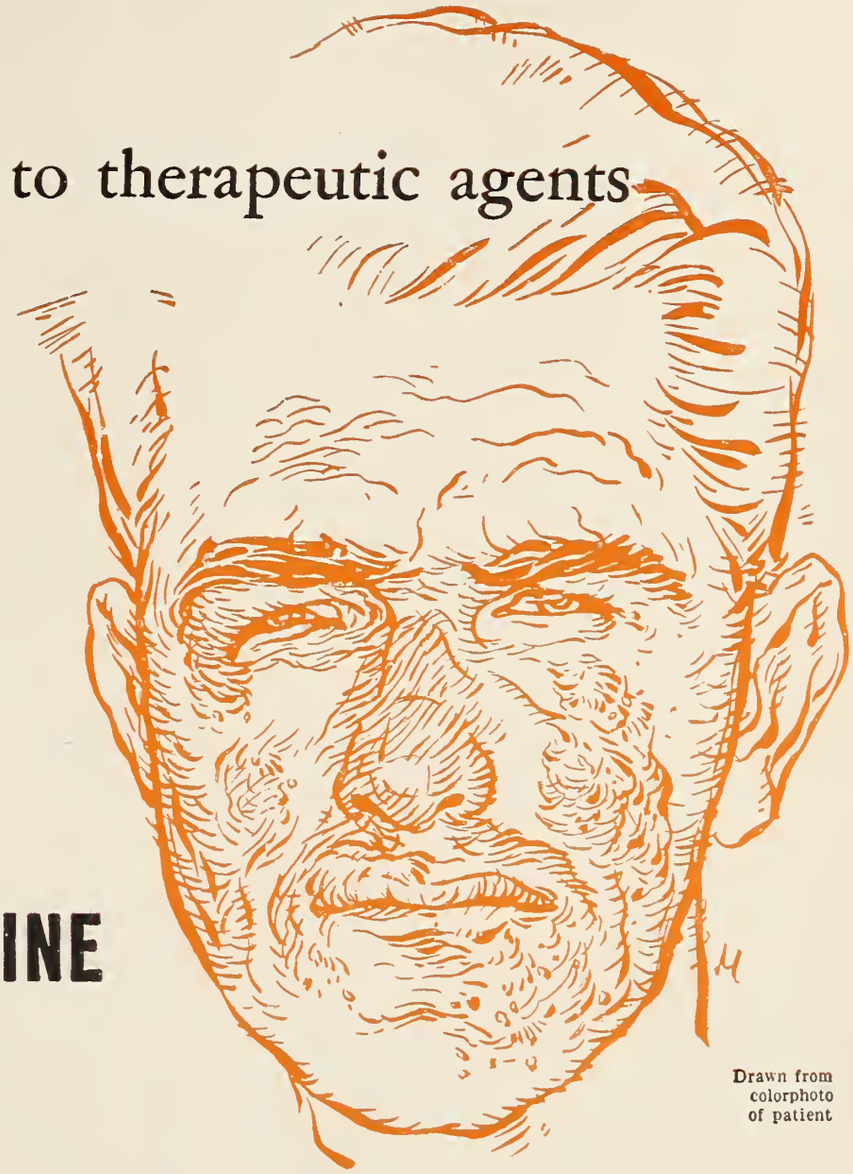
Dear Doctor:

Federal Security Administrator Ewing stumbled badly over a radio network recently when he discussed the pros and cons of his recently announced 10-year health program, including compulsory sickness insurance. Mr. Ewing was interviewed by three news commentators in a CBS broadcast from the "Capitol Cloak Room" on Wednesday night, Sept. 8, and he wobbled so badly that one doctor wrote: "Oscar gave me the impression he didn't know what his program was all about."

Interviewer: Mr. Ewing, in your health report, issued by the President the other day, you make a great point of the tremendous shortage of doctors in this country. You said, I think, that only about 80 per cent of those we need, there's whole counties without a single resident physician, what would be the effect on that

(Continued on Page 1192)

In sensitivity to therapeutic agents



Drawn from colorphoto of patient

PYRIBENZAMINE

maximal effectiveness with minimal side effects

Without inhibiting the formation of protective antibodies, Pyribenzamine hydrochloride will usually prevent or relieve symptoms of hypersensitivity produced by antibiotics, serums, or vaccines – allowing these valuable therapeutic agents to be used in many otherwise intolerant patients.

PYRIBENZAMINE SCORED TABLETS, 50 mg., bottles of 50, 500 and 1000.
PYRIBENZAMINE ELIXIR of 5 mg. per cc., bottles of 1 pint and 1 gallon.

CIBA PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

Ciba

PYRIBENZAMINE (brand of tripelennamine) Trade Mark Reg. U.S. Pat. Off. 2/1395M

AMA SECRETARY'S LETTER

(Continued from Page 1190)

shortage—would it be made worse by such a system of compulsory insurance?

EWING: Well, no. The medical profession is like any business. You only . . . people go into it to make a living out of it and the actual development of that profession is limited by the purchasing power of the people who get sick and you have in this country today, you have fully 70,000,000 people, half of our population, with incomes under $3,000, and they can't pay for adequate medical service and this insurance system will give an adequate purchasing power so that there can be adequate medical services given and that'll attract people into the profession.

INTERVIEWER: Well, do you think the doctors will be better off under such a program?

EWING: Very much so, Mr. Bancroft.

INTERVIEWER: Well, then why are they fighting it so hard?

EWING: I don't know. I think they've got a completely mistaken view about it. They bring up a lot of fantastic arguments that don't even have any application. They talk about there being politics in it. There's no place for politics. The thing is just as simple as I explained a few minutes ago, that a patient picks out a doctor that he would like to have as his physician and the physician decides whether he wants that person for a patient and then that establishes a relation and from there on it's simply the only difference in the existing situation instead of the patient paying the doctor, the doctor's paid for his services out of the insurance fund.

INTERVIEWER: Well, Mr. Ewing, aren't the doctors afraid of Government control actually? This is only an entering wedge?

EWING: Well, I'm not sure what they're afraid of. I think it's . . . I think good deal of it is lack of an understanding of just what it is. I think there's a great deal of emotional reaction among the medical profession to this thing. Actually, you can't mention insurance to a lot of doctors, they're so allergic to it that they break out in hives at the mere mention of the name.

Gleanings from Old Times

AN EXCITING RACE TO AID THE WOUNDED

Rivalry Between Harper and Grace Hospital That Caused Some Bad Feeling.

The great rivalry that exists between Grace and Harper Hospitals was never so apparent as it was Saturday afternoon when the report came of the big disaster. Both hospitals made strenuous efforts to have their ambulances on the scene of the fatality first. Harper Hospital is a block nearer the scene of the accident, but Grace Hospital ambulance got away first and was dashing by Harper Hospital when the ambulance of the latter dashed out of the driveway. The horse on the Harper wagon was the better runner and it soon made up the distance. Then there was a wild race down the street. The horses were neck and neck; they were going like mad. When the wagons came to a cross street, they would bounce in the air and sway from side to side. The gongs were beating; men, women and children stood and gasped in open-mouthed wonder. Something terrible had happened.

The Harper wagon finally drew away from the Grace, but it was a desperate struggle for supremancy. The reason for the Grace wagon getting away first was that the ambulance doctor had not stopped to take his ambulance cap out of the locker, and this is where he made a mistake, for when the ambulance reached the ruins a patrolman refused to allow him to pass the lines. He stormed and threatened, but the officer stood firm. Finally Capt. Mack of the Police Department happened along and gave the ambulance attache permission to assist in moving the wounded. The wagon succeeded in getting two and moved away. Harper had no trouble and hence the Grace Hospital waxed wroth. They called up Supt. Martin and then they called him down. The students at the hospital were even more angry than the officials. They declared that the Police force discriminated in favor of the Harper Hospital because Dr. Brodre, who is on the staff of that hospital, is the police department physician. A great deal more was said, but all contended that there was some satisfaction in knowing that all Harper got was four.

The total number of patients treated in Harper Hospital during 1898 was 4,509. The ambulance service made 1,120 runs. Seven hundred and one patients were taken to the hospital and 419 were taken to their homes. —Newspaper clipping, *Harper Hospital Scrapbook,* 1898.

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The JOURNAL

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President's Address

By P. L. Ledwidge, M.D.
President, Michigan State Medical Society
Detroit, Michigan



SINCE THE REPORT of Dr. Ray Lyman Wilbur's Committee on the Cost of Medical Care was published during President Hoover's administration, the question of the distribution of medical care has been constantly before the public. So far as the patient is concerned, this question automatically resolves itself into these parts: What medical care do I need? How best can I obtain it?

Efforts to answer these questions have presented many problems, two of which are basic and an immediate challenge to our profession: (1) to make available to every citizen of Michigan adequate medical care, near his own home, through the Doctor of Medicine of his own choice, and at a price he can reasonably afford to pay; (2) to maintain the practice of medicine as a free enterprise.

Each of these problems is dependent upon the other, each in itself is difficult of solution, and their ultimate solution to the satisfaction of profession and public alike is possible only by solving them together.

We must recognize that there is a need and an honest demand on the part of the public for more adequate medical care. There are many localities in our state where there are neither physical facilities nor a sufficient number of well-trained Doctors of Medicine to render proper medical service to all the people. Stimulating, supplementing, and overshadowing this legitimate public demand is a much more incessant demand by a large group of influential people whose objective is not only more adequate medical care but who seek specifically to change the whole method of distribution of medical care, from the practice of medicine as a free enterprise to the practice of medicine under direct governmental control financed by compulsory health insurance.

There is abundant proof of the accuracy of this statement. In the ten-year period from 1935 to 1944, inclusive, one hundred separate proposals for some form of compulsory health insurance were introduced into various state legislatures. Over one-third of these proposals were introduced in the last year of that period.

In a fairly recent session of the California State Legislature, a bill for compulsory health insurance failed to pass by only one vote. This bill had the active support of Governor Earl Warren of California, Republican nominee for the vice presidency of the United States.

Early in his administration, President Truman came out flatfootedly for a national health bill based on compulsory health insurance, when he might better have been concentrating on the less political but more essential problem of price and wage control until such time as full production in our industries would have assured a sound economy. The fact that President Truman's opening blast in the press in his present campaign (the Ewing report) dealt with compulsory health insurance is evidence enough of what we may expect if perchance he should be re-elected.

The Wagner-Murray-Dingell Bill has been introduced in three successive sessions of Congress.

Presented at the General Assembly, Michigan State Medical Society, Detroit, Michigan, September 22, 1948.

It was not until June of this year that a Senate resolution postponed its further consideration until next spring.

Long before the Emergency Maternity Infant Care program—a war measure—was terminated, the Pepper Bill was introduced. You will recall that this bill provided for care at government expense of all maternity cases and all children up to eighteen years of age, regardless of their financial status. It has been estimated that this group comprises about 40 per cent of our total population.

About one and one-half years ago an attempt to socialize medicine in the Philippines was made. This attempt was certainly encouraged, if not actually conceived, by certain people in the United States, among them a well-known professor of the University of Michigan.

In August, 1947, a Health Mission was sent to Japan to advise on the organization of a plan for distribution of medical care for the Japanese. It turns out that all of the members of that Commission were closely associated with the Social Security Board and are well-recognized advocates of compulsory health insurance. According to the now famous Harness report, they were spending United States tax money, yours and mine, illegally in support of socialized medicine.

During the 1947 session of the Michigan State Legislature, fifty-nine bills having to do directly or indirectly with health were introduced. So, you see, the public is being kept unusually health conscious at this time and some of the groups working on these health problems are far from friendly to organized medicine.

Now let's see what we are doing to meet these problems. Perhaps the first requisite for furnishing adequate medical care is to have our Doctors of Medicine well trained. To this end the Michigan State Medical Society, working with other groups, sponsors four types of postgraduate medical training:

1. The annual Scientific Assembly held in September each year.
2. The Annual Postgraduate Clinical Institute held in March.
3. Postgraduate courses at Wayne University College of Medicine and University of Michigan Medical School.
4. The short one to two-day courses held in the various postgraduate centers throughout the state.

Second in importance (perhaps it should be put first) in the matter of adequate medical care is the availability of the Doctor of Medicine who gives it. In this regard, I believe some of our members are falling down. For example, there are too many doctors who will not make night calls or even house calls, and there are too many places where all the Doctors of Medicine take the same afternoon off. During World War II several things that are not for the good of our profession happened. Those of us at home were too busy and too tired out to give the best type of medical care. Younger men, who because of physical handicaps or for other reasons were left at home, were immediately precipitated into large and lucrative practices without having to go through the lean years that constituted part of the training of most of us. With some, but by no means all, of the younger men this had a tendency to make them over emphasize their own convenience and to lessen their consideration for the rights of their patients. We as physicians should be easily available; we should be well prepared, and we should be willing to serve.

The problem of medical care for low-income groups has long been recognized by the Michigan State Medical Society. In 1939 the Enabling Act, sponsored by Michigan State Medical Society, was passed by the Michigan State Legislature. This act authorized Michigan Medical Service, a nonprofit prepaid service plan controlled by a Board of Directors, two-thirds of whom at least must be Doctors of Medicine. This plan now has well over 1,000,000 subscribers. It operates at an administrative expense of slightly less than 13 per cent, which means that over 87 per cent of all monies collected from subscribers is paid directly to those physicians and surgeons who render them medical service. From March, 1940, when it began operation, to August 31, 1948, it has paid out for such services $27,784,323.13.

Because of this splendid organization, we were prepared when the Veterans Administration began calling for help in 1946 to work with the physicians of Michigan in furnishing care for service-connected disabilities of veterans near their own homes by their family physicians, instead of having them sent to Veterans Clinics or Government Hospitals. For this service, Michigan Medical Service has paid out since 1946, $2,230,895.75, a grand total of about $30,000,000 handled by our own organ-

ization for the benefit of Michigan residents without profit and without compulsion.

Working with the Crippled Children's Commission, the Rheumatic Fever Program has been developed and is now an outstanding service to the people and medical profession of this state. This, as you know, is a diagnostic service where any Doctor of Medicine may refer a troublesome case for special diagnostic procedures and consultation for which the patient pays a small fee, if financially able. If not, the expense is met by the Crippled Children's Commission. The patient with the diagnostic findings is then referred back to his own physician for care. There are now twenty-seven Rheumatic Fever Centers in operation, and three more are being organized.

More recently, much attention has been paid to the matter of rural health. There is now under way and nearing completion a survey of actual health needs in rural communities. When the needs have been determined, efforts will be made to make practice in these communities more attractive to well-qualified young Doctors of Medicine. Special programs to prepare Michigan doctors for practice in rural areas are now being carried on by the University of Michigan Medical School, working with various hospitals throughout the state under a grant from the Kellogg Foundation. The Michigan Foundation for Medical and Health Education has provided a revolving loan fund for senior students and interns who will agree to spend their early years of practice in rural areas.

We have spoken of the unfavorable types of health legislation which are constantly being proposed. Much has been done to neutralize such proposals. I shall mention only a few. We approved the Federal Hospital Survey and Construction Act, which calls for matching Federal and State funds to build badly needed hospitals, and the state act necessary to implement the Federal law in Michigan. At the same time, we rejected a general hospital licensing bill as a rider to this act, insisting that if a general licensing law is desirable, it should be introduced as a separate bill and discussed on its own merits.

We sponsored the vivisection law which assures humane treatment of experimental animals and guarantees continuance of necessary animal experimentation. It prevented the passage of the antivivisection act.

During sessions of the Michigan State Legislature, our Legislative Committee is very active, and we have a constant watchdog from our executive office at the Capitol to check on every proposed bill that has to do with matters of health. This work, formerly done by our able Executive Secretary, Bill Burns, is now done by our Public Relations Counsel, Hugh Brenneman. I think we can truthfully say that no bill detrimental to the public health has been passed by our legislature in the last ten years. Incidentally, our Public Relations Program is being commended and copied in part by several other State Medical Societies.

In conclusion, it seems to us that each and every Doctor of Medicine in Michigan who believes in the American way of living, who values his privilege of practicing medicine as a free enterprise, and who realizes that socialized medicine is only one link in a strong chain of Socialism that threatens to shackle the American people, has certain obligations. What are these obligations?

1. It is his duty to keep himself informed on up-to-date scientific developments and clinical medicine.

2. He should be available and willing to render a satisfactory type of medical service to his patients, and have a reasonable regard for the patient's ability to pay when making his charges.

3. He should keep in mind the matter of personal public relations, so that each patient will have not only a close tie to his personal physician, but a friendly understanding of the problems of the medical profession as a whole.

4. He should be a militant member of his County and State Medical Societies and join with his colleagues in presenting a united front to the public, to the Congress of the United States, to the Michigan State Legislature, and to other public officials.

In this way, we may hope to accomplish the two objectives set for at the beginning of these remarks.

1. To make available to every citizen of Michigan adequate medical care near his own home, through the Doctor of Medicine of his own choice, and at a price he can reasonably afford to pay.

2. To maintain the practice of medicine as a free enterprise.

Early Contributions of Physicians Toward Tuberculosis Control in Michigan

By Andrew W. Kovacs
Lansing, Michigan

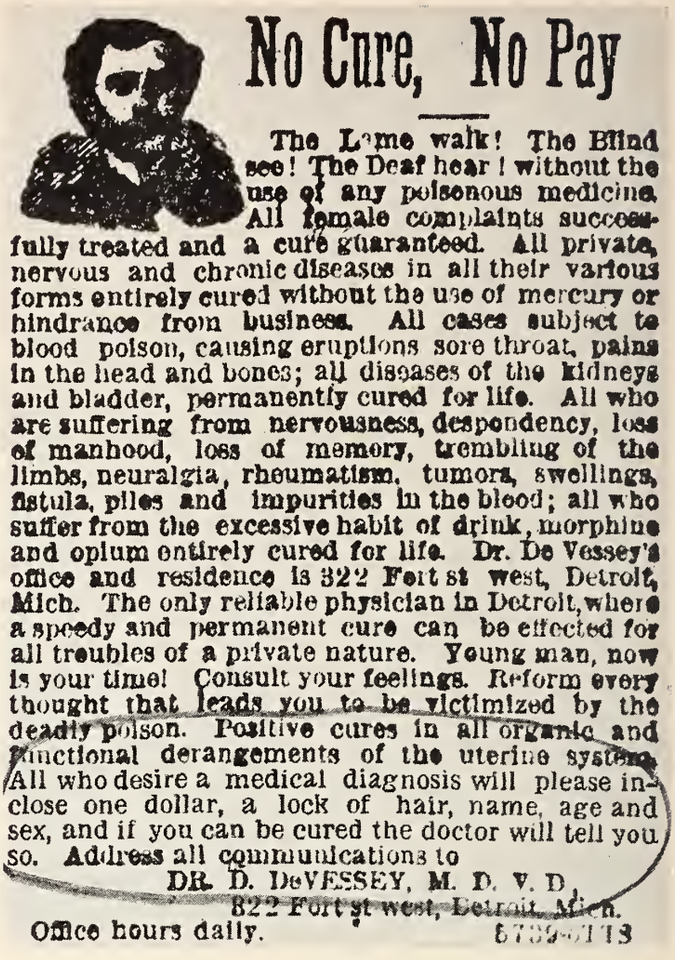
THE occasion of the 42nd Annual Christmas Seal drive is an appropriate one for outlining some early contributions of the medical profession toward tuberculosis control in this state. Without this contribution, which has never been adequately documented nor recognized, Michigan's progress against the White Plague would have been less rapid or at least much delayed. It is a pleasure to gather here for the first time a few of the highlights of a long-untold story.

The State Board of Health

There returned to Lansing in the year 1866 a young physician who had been a regimental medical officer in the Civil War. In the war he had learned that sickness took a greater toll than bullets, that preventing casualties due to disease was an important military consideration. He reasoned further that preventing disease was just as important in civil life. The doctor's name was Henry Brooks Baker.

Dr. Baker began practicing with Ira H. Bartholomew, M.D., then mayor of Lansing, and the two men often spoke of the feasibility of teaching the people how to avoid disease. They were stumped as to how this could be done, but the formation of the Massachusetts State Board of Health in 1869 gave them an example to follow. Early in 1870 Dr. Baker drafted legislation for a somewhat different type of state board for Michigan. Dr. Bartholomew was able to exert influence in favor of such a proposition when he was elected president of the Michigan State Medical Society in 1870.

Lacking laws to regulate the practice of medicine, Michigan in 1870 was a haven for the medical frauds who faced legal restrictions in other states. How to curb these and promote scientific medicine was an acute problem for the profession at that time. Medical leaders saw in the potential educational power of the proposed State Board of Health an opportunity to combat quackery and superstition as well as improve the public



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This is the kind of competition faced by legitimate practitioners before the practice of medicine was regulated in 1899. Taken from *The Evening News*, Detroit, March 21, 1882.

health. The support of the Society was thus assured and placed on record in the form of a resolution adopted at the meeting of 1871.

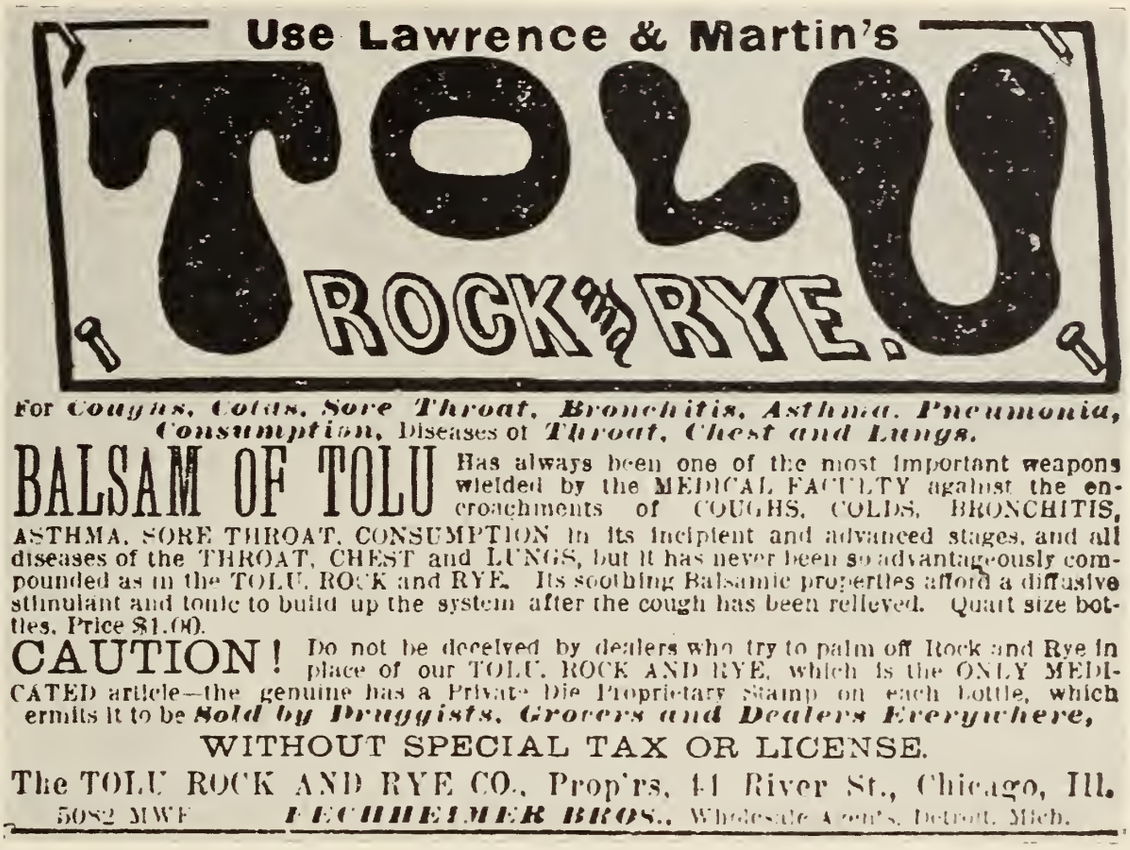
The physicians, in addition to Drs. Bartholomew and Baker, whose names are most frequently associated with the founding of the State Board of Health are: R. C. Kedzie, M.D., of Lansing; Homer O. Hitchcock, M.D., of Kalamazoo; Edward W. Jenks, M.D., of Detroit; Alonzo B. Palmer, M.D., of Ann Arbor; and George E. Ranney, M.D., of Lansing. One indication of the esteem in which these men were held by their colleagues are the offices which they held in the Michigan State Medical Society. Bartholomew, Hitchcock, Palmer, Jenks and Kedzie were all elected in the order named to serve as presidents, beginning in 1870. Dr. Ranney served the Society as secretary from 1866 until 1886 and was elevated to the presidency in 1891.

This first step, the founding of the State Board of Health in 1873, made the second possible. Dr. Kedzie had observed that farmers' institutes were useful in promoting the development of agriculture.

Mr. Kovacs is Research Editor of the Michigan Tuberculosis Association.

Why not similar meetings to advance the cause of public health? The outgrowth of this suggestion was the sanitary conventions which were first held in 1880.

erence to communicability was relatively short but Dr. Cogshall's paper, "Consumption; Is It a Contagious Disease? What Can Be Done To Prevent Its Ravages?" was devoted entirely to the subject.



Tolu Patent Medicine Advertisement

Medical societies, and later tuberculosis associations, fought hard to eliminate this kind of exploitation of tuberculous sufferers. Taken from *The Evening News*, Detroit, March 20, 1882.

The sanitary conventions were held one to four times a year, depending upon how much money was available, in towns throughout the state. They lasted from one to three days and leaned heavily upon local talent rather than outside speakers. The State Board of Health furnished them with the latest available material on public health problems. This accounts for the fact that from the beginning general practitioners took a prominent part in teaching the people that tuberculosis is communicable.

The famous Frenchman, Villemin, had published the reports of his animal inoculation experiments in 1865 and 1867. Other investigators followed his lead. On that basis there were some men in the state who already believed consumption to be communicable. To two of these, Henry B. Baker, M.D., and Bela Cogshall, M.D., of Flint, goes the honor of having first presented these facts to the people. This took place at the Battle Creek Sanitary Convention in March, 1881. Dr. Baker's reference to communicability was relatively short but Dr. Cogshall's paper, "Consumption; Is It a Contagious Disease? What Can Be Done To Prevent Its Ravages?" was devoted entirely to the subject. This paper was reprinted for general distribution, as was the entire proceedings of most of the conventions. Thus in 1881, one year before Robert Koch discovered the tubercle bacillus in Germany, the people were beginning to hear that one case of tuberculosis can only come from another.

To follow this thread further, soon after Koch made his epochal announcement in 1882 the results of his work were given to the people. At the Reed City Sanitary Convention held in April, 1883, F. J. Groner, M.D., of Big Rapids and L. S. Ellis, M.D., of Manistee, both dwelt on the importance of Koch's discovery. For a few years after that the subject seems to have been neglected, but beginning with Bion Whelan's paper at the Hillsdale convention in September, 1886, almost every subsequent meeting saw physicians advocating the communicability of consumption. These papers, as the previous ones, were issued in pamphlet form and are a matter of record in the library of the Michigan Department of Health.

These events provide the basis of a historic "first" which has but recently been claimed for Michigan. It has long been known that in New York City, Herman M. Biggs, M.D., and his



CUSPIDORS IN GENERAL USE IN THE 'EIGHTIES

These targets of many misses, from the fourteen-inch cuspidor on down, are symbols of an era during which spitting provided free transportation to billions of tubercle bacilli. Anti-spitting campaigns were among the first projects undertaken by tuberculosis associations.

associates, T. M. Prudden, M.D., and Alfred Loomis, M.D., submitted their recommendations for tuberculosis control in May, 1889, and that the prevention leaflet of the New York City Board of Health followed in July of the same year. This effort for many years has been considered the first attempt in this country to educate the people relative to communicability.

It is now clear that in Michigan communicability was first taught by Drs. Baker and Cogshall in 1881, that Dr. Cogshall's paper was reprinted as a pamphlet for general distribution, that Koch's findings were first presented in 1883 and became a regular feature of sanitary conventions in 1886. It appears, therefore, that to Michigan must go the honor of having the first program for educating the people relative to tuberculosis, an endeavor that was begun eight years before the program in New York. While it is true that the work resulted from the foresight of the State Board of Health, and especially its secretary, Dr. Baker, it is gratifying to note that many physicians helped make the sustained effort possible.

The Profession on Communicability

Although there were many physicians who accepted Koch's experimental results relatively soon, the issue of communicability was not settled for many years. The weight of tradition, which held that heredity, dampness and many other factors caused the disease, as well as the confusing slow growth of the tubercle bacillus, left many doubts in the minds of some men. The annual meetings of the Michigan State Medical Society played some part in resolving these doubts.

Until 1887 the transacting of business and the reading of scientific papers were all done at one session, and the agenda was always crowded. This occurrence partially accounts for the fact that no papers on Koch's experiments occur in the Society's Transactions for the years 1882-1887. In 1887, however, it was decided that three separate scientific sessions would be held in addition to the business session. This allowed more time for papers, and in 1888 occurred the first symposium on tuberculosis. There were three papers read at that meeting: "Do Undrained Lands Predispose to Phthisis Pulmonalis?" by Henry F. Lyster, M.D., of Detroit; "Aetiology of Tuberculosis," by Johann Flinterman, M.D., of Detroit; and "The Pathology of Acute Miliary Tuberculosis" by Heneage Gibbes, M.D., of the University of Michigan. Only Dr. Flinterman's paper contained the unqualified acceptance of the tubercle bacillus as the culprit in the disease. The discussion showed no clear-cut sentiment for or against this view, but the traditionally accepted causes received the most mention. Many physicians did not consider the issue settled.

The State Board of Health continued in the path it had chosen. Dr. Baker's views on communicability had formidable support. Serving on the Board since his appointment in 1883 was Victor C. Vaughan, M.D., Director of the State Laboratory of Hygiene at Ann Arbor. In the fall of 1888 Dr. Vaughan and F. G. Novy, M.D., journeyed to Europe to learn first hand from Koch and Pasteur about the budding science of bacteriology. Following their return, the teaching of bacteriology began at the University in January, 1889. Since the new knowledge was being imparted to medical students the State Board felt it was time to take a firmer stand on tuberculosis. This resulted in a leaflet on the prevention of the disease which appeared in September, 1891. This leaflet was a compromise. The importance of sputum disposal, requiring the patient to sleep alone and having fresh air and pure food for the patients were emphasized but nothing was said of isolation or the reporting of the disease.

In 1893, however, the Board took another step

which resulted in a Michigan "first." Isolation of cases, it was felt, was too advanced a step to be sustained by public opinion but the reporting of cases was not. Therefore, on September 30, 1893,

RESOLUTION ADOPTED BY THE MICHIGAN STATE BOARD OF HEALTH, SEPT. 30, 1893.

"*Resolved,* That hereafter, consumption (and other diseases due to the *Bacillus tuberculosis*) shall be included in the official list of 'Diseases dangerous to the public health,' referred to in sections 1675 and 1676 Howell's Statutes, requiring notice by householders and physicians to the local health officer, as soon as such disease is recognized."

[In this resolution the question of isolation of the patient is not mentioned. Its purpose is to secure to the local health authorities and to the State Board of Health information of the location of each case of this most dangerous disease, with the view of placing in the hands of the patient, reliable information how to avoid giving the disease to others, and in the hands of those most endangered, information how to avoid contracting this disease. HENRY B. BAKER, *Secretary.*]

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RESOLUTION OF STATE BOARD OF HEALTH (*Facsimile*)
This resolution is a proud Michigan first in U. S. public health history.

the Board approved its historic resolution which declared tuberculosis to be communicable and dangerous to the public health, hence reportable to health officers. This action preceded by a few months the series of events which led to the reporting of the disease in New York City.

This pioneering effort of the Michigan State Board of Health has received but passing mention in histories of tuberculosis control in the United States, yet it was the first action of its kind in the country. It is a source of great pleasure to record the names of the men, five of them physicians, who served on the Board at the time. They were: Victor C. Vaughan, M.D., Ann Arbor; Hon. Frank Wells, Lansing; Delos Fall, M.S., Albion; Samuel G. Milner, M.D., Grand Rapids; Mason W. Gray, M.D., Pontiac; George H. Granger, M.D., Bay City; Henry B. Baker, M.D., Lansing.

The Board's action brought interest in tuberculosis to a high pitch among the physicians of the state. Dr. Baker was invited to present the views of the Board to the Wayne County Medical Society. This he did in February, 1894. Although there was not unanimous acceptance concerning the role of the bacillus, the majority concurred. The Society adopted a resolution very similar to that of the Board.

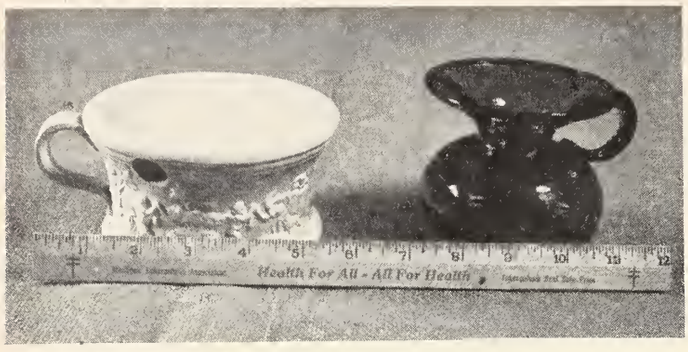
MSMS Meeting, 1894

The meeting of the Michigan State Medical Society in 1894 is important, for it can probably be considered the decisive weighting of the balance in favor of communicability. The five papers presented at the meeting were: "The Pathology and Etiology of Consumption," by Heneage Gibbes, M.D., of Ann Arbor; "Tuberculosis—Course and Varieties," by D. W. C. Wade, M.D., of Holly; "Treatment of Phthisis Pulmonalis," by E. L. Shurly, M.D., of Detroit; "Communicability and Prevention of Tuberculosis," by Frederick G. Novy, M.D., of Ann Arbor; and "The Relation of the State to Tuberculosis," by Henry B. Baker, M.D., of Lansing. Dr. Gibbes' thesis that there were non-bacillary as well as bacillary cases of tuberculosis did not withstand the probings of Dr. Novy and Dr. Vaughan. The majority seemed to accept the view that without the bacillus there could be no tuberculosis.

Between 1894 and 1900 much happened to accelerate the campaign against the White Plague. In Michigan the State Board of Health made an extended effort to acquaint the people with the nature of the disease. In 1895 Massachusetts passed the first law for a state sanatorium. The same year, a physicist at the University of Wurzburg in Germany discovered that the rays emitted by a Hittorf-Crookes tube could penetrate opaque substances. His name was Wilhelm Conrad Roentgen. In 1896 Theobald Smith, M.D., of Harvard, published his first findings on the bacillus of bovine tuberculosis. Announcing a discovery which had been made earlier and independently by Forlanini in Italy, J. B. Murphy, M.D., of Chicago in 1898 read his historic paper on artificial pneumothorax at the AMA meeting in Denver. Crowning this, and of particular significance to the profession in Michigan, was the passage of an effective medical practice law in 1899. The letters M.D. could no longer be used to label fraudulent imposters and accomplished phthisiologists alike.

MSMS Meeting, 1900

The meeting of the Michigan State Medical Society in 1900 marks several milestones in the tuberculosis campaign. First of all, the issue of



Sputum Cups

These sputum cups of the late Eighteen Hundreds are the predecessors of the disposable types of today.

communicability and etiology had been largely resolved, therefore, the emphasis was on what should be done. This was evident from the titles of the papers read: "Tuberculosis, Its Clinical History, Diagnosis and Prognosis," by George Dock, M.D., of Ann Arbor; "Medical Treatment of Pulmonary Tuberculosis," by Charles G. Jennings, M.D., of Detroit; "State Sanatoria in Michigan," by Herbert M. King, M.D., of Grand Rapids; "The Relation of Municipal Laboratories to the Control of Tuberculosis," by A. W. Crane, M.D., of Kalamazoo; and "The Administrative Control of Tuberculosis," by Collins H. Johnston, M.D., of Grand Rapids.

The second milestone was the appointment of a special sanatorium committee, the forerunner of the present Committee on Tuberculosis Control. The State Board of Health had presented its original request for a state sanatorium to the Legislature in 1895. This had been rejected along with similar requests in 1897 and 1899. The Michigan State Medical Society had not participated in these moves. By 1900 many physicians felt the Society should take a stronger role in behalf of a state sanatorium. Accordingly, Herbert M. King, M.D., of Grand Rapids, submitted a resolution urging the Society to appoint a committee for that purpose. Upon the motion of Collins H. Johnston, M.D., of Grand Rapids, the resolution passed. Dr. King, Dr. Johnston and Hugh McColl, M.D., of Lapeer, were appointed members of that first committee.

It took this committee and its successors five years—three legislative sessions—to produce results. In addition to the men already named, the physicians who served on this committee between 1900 and 1905 were the following: Lyman W. Bliss, M.D., Saginaw; Victor C. Vaughan, M.D., Ann Arbor; B. D. Harison, M.D., Sault Ste. Marie;



Old Oaken Bucket and Dipper.

The old oaken bucket and dipper were colorful parts of the American scene several decades ago. The dipper, as it passed from mouth to mouth, was also an efficient way of spreading tuberculosis.

J. B. Whinery, M.D., Grand Rapids; C. N. Sowers, M.D., Benton Harbor; C. G. Jennings, M.D., Detroit; Henry B. Baker, M.D., Lansing; H. J. Hartz, M.D., Detroit; B. F. Horner, M.D., Lake Odessa; B. R. Shurly, M.D., Detroit.

In 1905, with generous assists from the newly formed tuberculosis societies in Detroit and Grand Rapids, the legislation which led to the establishment of Michigan State Sanatorium at Howell was secured.

In 1903, while this committee was still working on its assignment, a movement was begun by E. L. Shurly, M.D., to provide some facilities to care for the tuberculous of Detroit. Through the aid of Otto Scherer, M.D., this resulted in the establishment of a tent colony on the grounds of the Wayne County Poor Farm at Eloise, the first special provision so far as is known for consumptives in this state.

It has been stated that tuberculosis societies assisted in securing the sanatorium legislation of 1905. Physicians took a prominent part in establishing these societies. One year earlier, in 1904, what is now known as the National Tuberculosis Association was founded. Two Michigan men, V. C. Vaughan and Henry B. Baker, were among the founders of this organization. A third, Herbert

M. King, M.D., was also a founder, but in 1904 he had left Grand Rapids to accept the superintendency of Loomis Sanatorium at Liberty, N. Y. He is therefore listed among the New York founders. The formation of a national association, as well as the need for lay support in securing sanatorium legislation, led to the formation of local societies.

Instrumental in forming the Grand Rapids Anti-Tuberculosis Society, which first met on March 3, 1905, were: Arthur W. Stace, then a reporter for the *Evening Press,* now editor of the *Ann Arbor News*; Samuel H. Ranck, librarian; V. C. Vaughan, M.D., of Ann Arbor, and Collins H. Johnston, M.D., of Grand Rapids. According to Mr. Stace, Herbert M. King, M.D., also assisted before leaving Grand Rapids.

The Detroit Society for the Study and Prevention of Tuberculosis was organized on March 21, 1905. According to one account the physicians who laid the foundation were H. J. Hartz, M.D., and E. S. Sherrill, M.D., of Detroit, and S. A. Knopf, M.D., of New York. It is also known that Mr. E. G. Pipp, Managing Editor of the *Detroit News,* gave valuable assistance. Apparently there were more physicians who assisted in the organization, but the Michigan Tuberculosis Association's records of the event are incomplete.

The Battle Creek Anti-Tuberculosis Association, which completed its organization in May, 1905, resulted largely from the work of John Harvey Kellogg, M.D.

Permanent Committee on Tuberculosis Control

The sanatorium committee appointed by the State Medical Society was discharged in 1905 after its report of success. Interest in tuberculosis was growing, however, and it was inevitable that the medical profession should feel responsible for leading the way. To provide a means of doing this was the object of W. E. Coates, M.D., of Onekama, when he proposed to the Society in 1906 the formation of a permanent committee. This resolution was favorably received, and the Committee on the Study and Prevention of Tuberculosis was appointed. The members of the committee and their duties were as follows: W. E. Coates, M.D., of Onekama, chairman, in charge of organizing local groups; George Dock, M.D., of Ann Arbor, diagnosis and general treatment; Casper K. LaHuis, M.D., of Kalamazoo, organization work in the southwestern part of the state; E. L. Shurly, M.D., of Detroit, therapeutics; P. M. Hickey, M.D., of Detroit, x-ray in diagnosis, organization work; Alden H. Williams, M.D., of Grand Rapids, pathology and organization work; F. McD. Harkin, M.D., of Marquette, organization work in the Upper Peninsula.



Tent Hospital at Eloise.
This is a view of the hospital tent erected at Eloise in 1903, the first special facilities for caring for the tuberculous in Michigan.

The duties assigned to the committee members have been listed to show the broad scope of work it was hoped to undertake. It is significant that the formation of local medical and lay groups was considered a necessity from the very first.

A few of the accomplishments of the committee were:

1. Committees were formed among the physicians of Wayne County and Grand Rapids to assist the local tuberculosis societies.
2. A special committee of the Kalamazoo Academy of Medicine undertook a campaign of education among the people.
3. The Manistee County Medical Society organized the Onekama Heights Sanatorium Association in March, 1906, with W. E. Coates, M.D., as medical director. This was a small tent colony which did not last long but it was an attempt.
4. Following the State Committee's suggestion, many county societies arranged special programs and papers on tuberculosis.

One indirect accomplishment of the committee is worthy of extended mention. Under the guidance of F. McD. Harkin, M.D., of Marquette, the Upper Peninsula Medical Society organized the Upper Peninsula Association for the Prevention and Cure of Contagious and Infectious Diseases. This group, consisting mainly of health officers,

supervisors and physicians, felt that the Upper Peninsula should have a state sanatorium and that counties should be permitted to build communicable disease hospitals and sanatoria. The second objective required a constitutional amendment. When the Constitution Convention of 1908 met in October, representatives of the group were there and succeeded in securing Section 11, Article VIII, which gives counties the constitutional right to establish sanatoria.

The constitutional amendment was only the first step. Specific laws were needed. When the Legislature convened in 1909, the same Upper Peninsula Association was ready with two bills, one for a state sanatorium and one granting counties specific power to build sanatoria. Only the second one passed. Thus, what started with the appointment of the State Society's first permanent committee on tuberculosis culminated in Michigan's first county sanatorium law.

Rise of Tuberculosis Associations

These contributions, although significant, fell short of what the Tuberculosis Committee hoped to do. Indeed, it is a tribute that busy practitioners undertook to do so much. After two years of work, it became obvious that a greater effort, a full-time effort, was needed. Physicians were soon able to help create one.

Anti-tuberculosis forces in this country were preparing to be hosts to the International Congress on Tuberculosis to be held at Washington in September, 1908. The national committee preparing for the event hoped that each state would be represented. This committee appointed a Michigan committee to organize the participation of this state. The men named, all doctors of medicine, were: Collins H. Johnston of Grand Rapids, C. G. Jennings and Henry J. Hartz of Detroit; and George Dock, V. C. Vaughan, F. G. Novy, C. B. deNancrede and A. S. Warthin of Ann Arbor. When this group met in Ann Arbor on December 6, 1907, it was decided to organize not only for the International Congress but for the full-time fight against tuberculosis. For this purpose, about 300 medical and civic leaders were called together in Detroit on February 21, 1908, to organize the Michigan Association for the Study and Prevention of Tuberculosis, the antecedent of the present Michigan Tuberculosis Association.

The influence of physicians was marked in the new organization. Of the five officers four were physicians: C. G. Jennings of Detroit, president; R. T. Abrams of Dollar Bay, second vice president; A. S. Warthin of Ann Arbor, secretary; and H. J. Hartz of Detroit, treasurer. Of the seven Executive Committee members five were physicians: V. C. Vaughan of Ann Arbor, chairman; Guy L. Kiefer of Detroit; F. W. Shumway of Lansing; and the president and secretary. Of the thirty members on the Board of Directors seventeen were M.D.s.

The labors of the physicians did not end there. During the first year, the Association called upon the doctors of 110 communities in the state to organize local committees and associations. As a result, forty local branches were organized the first year.

By 1909 the tuberculosis campaign had two of the essentials for successful work, medical leadership and lay participation. These two elements, however, could not be fully utilized for lack of a third—adequate financing. The raising of funds was largely limited to membership dues, although the Detroit Society supplemented this by a Tuberculosis Charity or Blue Star Tag Day. The State Association adopted the Blue Star symbol and also an Easter Stamp, but the success of these devices as fund raisers was limited. The year ending February 26, 1909, showed only $787.50 available for State Association use. The next year brought a slight improvement, but the $1,900 income was barely enough to keep the organization together.

It was in Houghton County, apparently, that the present means of raising funds was first used. The annual report of the Houghton County Anti-Tuberculosis Society for 1908-1909 shows that a little over $1,000 was raised by the sale of locally designed "Christmas stamps" in 1908. In 1909, Detroit and Grand Rapids used the Red Cross Christmas Seal and found it to be effective. The State Association, however, was slower in adopting its use, for it was not until 1911 that Michigan had its first state-wide Red Cross Christmas Seal sale.

The Red Cross Christmas Seal, which became the Tuberculosis Christmas Seal in 1919, has proved its effectiveness in the voluntary fight. Not only has it made possible the scope of work envisaged by the State Medical Society's first Tuberculosis Control Committee in 1906, in the process it has reminded Michigan's citizens for forty years that concerted action alone will suffice to wipe out the waxy tubercle bacillus.

Aims and Objectives of Research in Tuberculosis

By Esmond R. Long, M.D.
New York, New York

RESEARCH ON TUBERCULOSIS is aimed at control of the disease through prevention or cure. There is no simple shortcut, however, to these objectives. In a number of diseases, happy circumstance, through the discovery of an antitoxin or a drug with a sterilizing effect on the germ causing the disease, has enabled control of the infection. In the majority of diseases, such a shortcut has not been discovered. Among these is tuberculosis. So much research has been done upon this disease that it is unlikely that a preventive or cure will be discovered suddenly. For this reason, research is directed toward fundamental aspects of the disease that may enable control finally through long and well-thought-out enterprise.

The Committee on Medical Research of the National Tuberculosis Association has long been concerned with fundamental laboratory investigations throwing light upon the intimate nature of the tubercle bacillus and the physiological processes by which it lives. At the same time, the Committee has sponsored clinical investigations which furnish better understanding of the progress and prognosis of different forms of tuberculosis and related conditions which sometimes offer difficulty in diagnosis.

These investigations are often of a highly technical nature and, because of their complexity, proceed slowly. A large group of studies sponsored for many years by the National Tuberculosis Association is concerned with chemical analyses of the different elements entering into the composition of the tubercle bacillus and the medium on which it has grown. These investigations have given us a remarkable understanding of the exact nature of the bacillus. At the same time, they have permitted the production of useful pure substances, such as the purified tuberculin now widely used in surveys of school and other large population groups. The chief reason for their continuation, however, is the hope that vulnerable points will be discovered in the life processes of the tubercle bacillus, which will enable trained investigators to suggest means of interposing obstacles either to the essential life processes of the germ or to its synthesis of new materials for its body structure. Such investigations are intimately tied with research on the manner in which such drugs as streptomycin act.

Among the clinical and epidemiological studies sponsored by the National Tuberculosis Association, on the recommendation of its Committee on Medical Research, two may be cited as of unusual interest in indicating the objectives of research on these aspects of the disease.

One of these, a co-operative enterprise with the United States Public Health Service, is directed toward an exact determination of the course and prognosis of tuberculosis when it is discovered in the minimal stage. It must be assumed that, in general, advanced and fatal tuberculosis was at one time tuberculosis of minimal extent. It is well known that many cases of minimal extent heal easily and spontaneously with little care. Others progress to a fatal issue. The reason why many cases of minimal tuberculosis go on to the advanced and often hopeless state is not as clear as might be supposed. The current large study, based on many thousands of cases, is expected to yield valuable information on this most important point.

The other clinical study has to do with the course of tuberculosis in childhood. Childhood tuberculosis, fortunately, is rapidly coming under control. Yet the fact remains that many children still acquire lesions early in life. These may be a menace to future health through the establishment of latent foci which remain dormant for years and ultimately progress to disease in adult life. Exact investigation of the relation of progression of the disease in childhood to the age of the child, time of first infection, type of care given, nutritional state of the child and other factors, is yielding information which should be of great importance in determining what are the best means for protection.

In addition, the Committee on Medical Research of the National Tuberculosis Association has taken a prominent part in the promotion of the current promising investigations on streptomycin and other antibacterial drugs which may be useful in the treatment of tuberculosis. Information on this large and important subject will appear from time to time in publications of the National Tuberculosis Association.

These few examples from the long list of projects sponsored by the National Tuberculosis As-

Dr. Long is Director of Research and Therapy, National Tuberculosis Association.

sociation through its Committee on Medical Research serve to illustrate the breadth and scope of research and the ultimate aims. This research is financed by funds raised in the annual Christmas Seal Sale of the National Tuberculosis Association and its 3,000 affiliated associations. Through these fundamental investigations, results of great practical value may be expected for the welfare of each individual who has tuberculosis or is exposed to this disease.

EDITOR'S NOTE: Five per cent of the money raised through the sale of tuberculosis Christmas Seals in Michigan is forwarded by the Michigan Tuberculosis Association to the National Tuberculosis Association for the campaign against tuberculosis and research on the disease. In addition, the Michigan Tuberculosis Association provides Christmas Seal funds for special Michigan tuberculosis research projects. Case-finding, health education and rehabilitation of tuberculous patients are other programs promoted by the Christmas Seal in Michigan.

MSMS

MASS EFFORT FOR TUBERCULOSIS CONTROL

The striking decline in the mortality from tuberculosis in recent years has been attributed to the subjecting of millions of persons to x-ray chest examination. This results in early diagnosis of unsuspected cases. But this step is only the beginning. Patients must be induced to seek the medical care they need and provision for this must be made. The best way to carry out such a program seems to be to make a mass effort covering an entire city. This was done recently in Washington, D. C., an account of which by Dr. Francis J. Weber appears in *Public Health Reports* (Vol. 63, p. 737). It involved the co-operation of the official health agency, the local voluntary association and the medical profession. Citizens' committees directed by leaders in every field of civic enterprise carried out the difficult task of bringing the population before the penetrating rays of the x-ray apparatus. Such mass action stimulates the mobilization of community resources for a long-range, tuberculosis-control campaign. In 1947, tuberculosis mortality dropped to 33.2 per hundred thousand of population as against 36.4 the previous year.

* * *

There is apparently no way of predicting the subsequent evolution of the incipient minimal lesion in tuberculosis other than by actual observation of its behavior over a considerable period of time. Neither the age of the patient, nor the location or roentgenological appearance of the lesion, could be regarded as dependable guides for estimating the relative risk of progressive disease.—DAVID REISNER, M.D., *Am. Rev. Tuberc.*, March, 1948.

* * *

There can be no isolationism in the field of health. The fight against infectious disease is not a national or racial problem; it is a task for the whole of humanity. . . . The all-inclusive objective of any sound tuberculosis program is the prevention and eventual eradication of tuberculosis from the peoples of the world.—*Bull. World Health Organization,* 1948.

Results of a Co-operative Study on the Effects of Streptomycin

By John B. Barnwell, M. D.
Washington, D. C.

IN THE SPRING of 1946, the Veterans Administration, acting in co-operation with the Army and Navy, undertook a clinical study of the affects of streptomycin upon tuberculosis. Approximately 3,000 cases had completed treatment in 48 hospitals prior to April of 1948, at which time a conference of the participating investigators was held in Chicago. The data which were presented to that conference form the substance of the present paper.

All types of tuberculosis are represented in the series, and in rather formidable numbers. All patients were treated under the terms of protocols which were varied from time to time to permit exploration of various regimens, but which were uniform in requiring bacteriological or pathological proof of the diagnosis, in requiring that the disease be not improving at the time treatment was instituted, and in listing the clinical and laboratory observations which were to be made on each case. In the beginning of the study, no variation in treatment other than the addition of streptomycin was permitted although, latterly various surgical procedures and other drugs have been used in combination with streptomycin.

Twenty of the first 100 cases of meningeal and miliary tuberculosis who were treated with streptomycin have survived more than 12 months following the completion of their treatment. The most constant favorable results have been observed in lesions involving the larynx, the tracheo-bronchial tree, the alimentary tract, the peritoneum and in the case of draining cutaneous sinuses. In genito-urinary disease, symptomatic relief has been very common and the lesions of the lower urinary tract have usually healed. Radiologic improvement of tuberculosis involving bone and joint appears to be genuine but is slow to appear and, usually, slight in degree. There is now no question but that streptomycin can favorably affect pulmonary disease, and this is particularly true in the case of recent exudative lesions. The radiologic clearing which

Presented at the Eighty-third Annual Session of the Michigan State Medical Society, Detroit, September 23, 1948.

results is, however, rarely complete and only with equal rarity can streptomycin be thought of as providing definitive therapy. On this account and because of the frequency (some 30 per cent) with which relapses occur following the completion of treatment, or even during its course, streptomycin must be considered as an adjuvant to other forms of therapy in pulmonary tuberculosis.

The results which have been mentioned were attained with a daily dose of 2.0 gms. given for 120 consecutive days, the regimen originally chosen by the investigators. This regimen, however, produced a number of toxic manifestations, notably subjective and objective evidence of damage to the vestibular branch of the eighth cranial nerve in nearly 80 per cent of the patients. Efforts were made to resolve this difficulty by decreasing the dosage and duration of treatment. It developed that a reduction in dosage to 1.0 gm./day, given in two rather than in five injections, resulted in markedly decreased toxicity without any loss of therapeutic efficacy; nor did a reduction in the duration of treatment to 60 days sensibly diminish its efficacy in the case of pulmonary tuberculosis. A further reduction in daily dosage to 0.5 gms. to all intents and purposes abolished important toxic signs but it may be that some therapeutic effects are lost when this is done.

While the disadvantage of toxicity can thus be largely avoided by decreasing the dosage of streptomycin, the disadvantage of producing streptomycin-resistant organisms in the patient under treatment has not been avoided by this means. The use of still shorter courses of treatment, of interrupted treatment, and of treatment by streptomycin in combination with other drugs, are all being explored in an attempt to avoid this complication of therapy.

In short, to abstract this abstract, the original observations of Hinshaw and his collaborates have been confirmed in impressive numbers of patients, certain additional points have been developed—particularly in connection with dosage—and the questions which remain to be answered have been brought into quite sharp focus.

MSMS

DO YOU KNOW?

Albacore is the choicest species of tuna fish; its meat is white.

Although known to be a native of the American continent, the exact origin of the common white potato is unknown.—*Science News Letter,* October 23, 1948.

The Use of Streptomycin in Tuberculosis

By Committee of Chemotherapy and Antibiotics, American College of Chest Physicians

THE COMMITTEE on Chemotherapy and Antibiotics of the American College of Chest Physicians submits the following report of the use of streptomycin in tuberculosis.

Indications for Treatment

Nearly all forms of tuberculosis respond to treatment with streptomycin in some degree. However, the drug should by no means be used indiscriminately.

Pulmonary Tuberculosis.—It is extremely difficult to lay down hard and fast rules for the use of streptomycin in pulmonary tuberculosis. Especial care in the selection of cases is necessary. The drug has its greatest usefulness in cases with an appreciable amount of exudative disease. In some other cases streptomycin is responsible for symptomatic improvement and the prevention of complications.

1. Definitive treatment: This category includes chiefly progressive lesions of recent origin with little or no destruction of tissue, such as progressive primary tuberculosis and tuberculosis due to hematogenic and bronchiogenic dissemination.

2. Preparation for surgical procedures, including temporary and permanent collapse and excisional surgery. In some cases pneumothorax can be instituted sooner and with greater safety after a course of streptomycin. Not infrequently the drug is of great value in preparing patients as candidates for thoracoplasty. As prophylaxis, streptomycin should be used routinely in excisional procedures.

It must be emphasized again and again that streptomycin is *not* a substitute for sanatorium care and other proven procedures. Rather it is a valuable adjunct to these other measures.

Extrapulmonary Tuberculosis.—Streptomycin is the only treatment available in miliary tuberculosis and tuberculous meningitis. In such cases early and intensive treatment is imperative. Streptomycin is the treatment of choice for tuberculous

sinuses, tuberculosis of the oropharynx, larynx and tracheobronchial tree, tuberculous enteritis and peritonitis, tuberculous otitis media, and tuberculous pericarditis. In renal tuberculosis, symptomatic improvement is usually prolonged and bacterial conversion occurs in some cases. Tuberculosis of the bones and joints is often improved by streptomycin but chemotherapy is not a substitute for orthopedic surgery when this is indicated.

Streptomycin is valuable as pre-operative and post-operative treatment of tuberculosis in surgery of the genito-urinary tract, surgery of bones and joints, pericardiolysis, incision and drainage of abscesses and fistuectomy.

Administration

Streptomycin is administered by intramuscular or deep subcutaneous injection. The optimal regimen for the administration of streptomycin has not been determined. In most forms of tuberculosis results appear to be satisfactory when a dose of .5 to 1 gram a day are administered in one or two injections for six to eight weeks. With this mode of therapy complications are very infrequent and in most cases their clinical importance may be discounted. In tuberculous meningitis and miliary tuberculosis treatment should be vigorous; a dose as high as two grams per day for four months, or longer if necessary. In tuberculous meningitis results seemingly are better when intramuscular injection is supplemented by intrathecal injection of from 25 to 50 milligrams every twenty-four to forty-eight hours for two or three months, or as long as this method of administration is tolerated by the patient.

Since drug fastness is apparently closely related to duration of treatment, regardless of the daily dosage, limitation of the period to a few weeks may be effective in avoiding this phenomenon in many cases.

The physician handling a case of tuberculosis would do well to ask himself the following questions before administering streptomycin:

1. Why is streptomycin being used: for definitive therapy, as preparation for surgery, for prophylaxis, or for relief of distressing symptoms?

2. Is the type of lesion present of such a nature as to warrant the use of streptomycin in addition to other available therapy?

3. Can the purpose of chemotherapy be accomplished within the relatively short period of the drug's effectiveness? (Almost three-fourths of the patients show resistant organisms after three to four months of continuous daily streptomycin treatment.)

Other Chemical and Antibiotic Substances

There is no other substance known today which compares with streptomycin in its effectiveness against tuberculosis. The sulfones, promin and promizole, are generally ineffective alone. Experimental work is in process to determine whether or not there is synergistic action when any of these are added to streptomycin. Para-aminosalicylic acid is promising on the basis of laboratory experimentation but sufficient clinical work has not yet been done to permit evaluation of this drug. Subtilin has not had sufficient clinical trial and there is not yet enough animal experimentation to indicate its usefulness. Of the many other antibiotic substances, none has shown in preliminary experimentation indication of real value against tuberculosis and none has had clinical trial.

Submitted for the Committee on the Management and Treatment of Diseases of the Chest by the Sub-Committee on Chemotherapy and Antibiotics.

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Clinical Evaluation of Functional Studies of the Liver

By Bruce C. Lockwood, M.D.
Detroit, Michigan



RECENT YEARS have seen an extension and a re-appraisal of our knowledge regarding liver physiology and of the clinical laboratory tests for the detection and study of liver abnormalities.

The liver is the largest gland in the body, the great central laboratory of metabolism, and it plays many active roles in the maintainance of health. It is obvious, therefore, that no single liver function test can measure all of these activities. Extensive study has clarified the situation however, so that numerous of the tests have been found to be of great clinical value in certain situations. It is now deemed advisable to include certain of the tests in routine internal medicine examinations in the office as well as in the hospital, because by no other means can early liver disease be detected.

It is well, in order to better understand the clinical application of liver function tests, to review the normal physiology of the liver. These activities are outlined and classified briefly as follows:[1,2,5]

Excretory Functions of the Liver

The excretory functions of the liver include the formation and excretion of bile and its constituents. Normal hepatic bile amounts to about 800 c.c. daily, and consists of approximately 97 per cent water, 1.0 per cent bile salts; 0.1 per cent bilirubin, 0.1 per cent cholesterol, 0.1 per cent lecithin, 0.1 per cent fats, and 0.1 per cent inorganic salts of calcium, sodium, potassium, and the magnesium salts of phosphates, chlorides and carbonate.

The Bile Salts are the sodium salts of glycocholic and tuarocholic acid and are specific secretions of the hepatic cells. They are salts of cholic acid, which is a derivative of cholane. Substances of similar chemical structure are cholesterol, ergosterol, vitamin D, estrogen and testosterone. There is an enterohepatic circulation of bile salts so that only about 10 per cent are lost daily in the feces. The bile salts serve a useful function in the intestine by: (1) lowering surface tension, thereby emulsifying fats and aiding ferment action, (2) fatty acids unite with bile salts before absorption, (3) the fat soluble vitamins A, B, E and K are aided in absorption, (4) they are slightly laxative, (5) they inhibit putrifaction, (6) stimulate bile formation, and (7) help to hold cholesterol in solution in the bile.

Bilirubin is a derivative of the iron-free pigment fraction of destroyed hemoglobin. It is formed by the reticuloendothelial cells throughout the body but chiefly in the liver (Kupffer cells), the spleen, and the bone marrow. This bilirubin retains the globin fraction of the porphyrin ring and is designated bilirubin-globin[15] or hemo-bilirubin until it is excreted by the liver polygonal cells, during which process the globin fraction is removed, and the free bilirubin substance is then called chole-bilirubin.

Serum chole-bilirubin reacts promptly with the Van den Bergh diazo reagent, and such test is called the direct, prompt or one-minute reaction. Hemo-bilirubin has a delayed reaction, which, however, may be speeded up by the addition of alcohol and is called the indirect reaction. The total bilirubin in the serum is the sum of the prompt reacting chole-bilirubin and the indirect reacting hemo-bilirubin.

The total bilirubin normally found in human serum is seldom over 1.0 mg. per 100 c.c. of which the prompt one-minute reacting or chole-bilirubin should not exceed 0.2 mg. per 100 c.c. An increase of this prompt-reacting bilirubin represents that which after having been secreted by the liver has been returned to the blood through the lymphatics of the large or small bile ducts due to obstruction in the extrahepatic bile ducts or at times in the small bile capillaries. This condition is usually associated with a regurgitation of other elements of the bile such as phosphates, bile salts and cholesterol. An increase of the indirect reacting hemo-bilirium is due either to excessive production as occurs in hemolytic jaundice, or to hepato-cellular injury (infections or poisons), or also to a rare condition called constitutional hepatic dysfunction. It should be emphasized that in all cases of regurgitation (obstruction) jaundice (high

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direct one-minute reacting bilirubin) there is produced enough dysfunction of the liver polygonal cells so that there is also a retention jaundice (high indirect reacting bilirubin).

Urobilinogen is formed by a reduction of bilirubin by anaerobic bacteria in the colon. If bile is completely obstructed from the intestine, no urobilinogen can be formed. It is colorless, but gives an intense reaction with the Ehrlich reagent. Urobilinogen when allowed to oxidize changes to urobilin which has a yellowish color.

A varying amount of the urobilinogen formed in the colon is absorbed through the portal vessels and returned to the liver. An average of about half of the bilirubin excreted in the bile is thusly reabsorbed as urobilinogen; more in case of constipation but very little in case of diarrhea.[15] Normally the urobilinogen is disposed of by the liver rather completely, and not more than 3.0 mg. escapes into the urine in twenty-four hours, and this amount seldom shows more than a trace with the qualitative test. Increased amounts however indicate diffuse hepato-cellular damage, and in marked liver damage as much as 100 mg. may be found in the urine in twenty-four hours. In case of complete biliary obstruction when no bile is reaching the intestine, there obviously can be no urobilinogen formed to escape through the liver and into the urine.

Cholesterol is a metabolic waste product, especially derived from animal fat. It is the chief constituent of gall stones.

Porphyrin is found in increased quantities in the urine in liver disease, which indicates that normally the liver has been excreting this pigment.[15]

Metabolic Functions of the Liver

Carbohydrate Metabolism.—

1. The liver changes absorbed glucose, galactose and levulose (monosaccharide) to glycogen (polysaccharide) and stores it. This change is initiated by the liver enzyme hexokinase, glucose is changed to glucose -6- phosphate, then to glucose -1- phosphate, then to glycogen. This liver enzyme hexokinase is activated by insulin, but inhibited by anterior pituitary and by adrenal cortex.[3,6,11]
2. It changes 40 per cent of protein to glycogen.
3. It changes some fatty acids to glycogen.
4. It regulates blood sugar by converting some of its glycogen reserve to glucose and releasing it into the blood stream when needed to maintain normal blood sugar. This is done by means of the enzyme phosphatase.[3] Adrenal medula (adrenalin) accelerates the change of liver glycogen to glucose.

Protein Metabolism.—

1. The liver synthesizes amino acids to urea and uric acid.
2. It makes most of the protein of blood serum, notably the albumin, globulin, fibrinogen, and prothrombin.
3. It stores some protein.

Fat Metabolism.—

1. The liver oxidizes fatty acids to the ketone bodies, acetone, diacetic and bea-oxybutyric acid. This enzyme action is accelerated by anterior pituitary and adrenal cortex but retarded by insulin.[3]
2. It stores the cholesterol derived from food and combines it with fatty acids to form cholesterol esters which help the transportation of fat throughout the body. Normally 75 per cent of blood cholesterol is in ester form. It controls blood cholesterol.
3. It stores some fat, dependent on other general fat deposits of the individual. This may be influenced by several toxic agents.
4. It makes some fat from glucose.

Water Metabolism.—The liver acts as a reservoir for water and blood, and thereby helps to regulate blood volume.

Vitamin Metabolism.—

1. The liver makes vitamin A from carotene and stores vitamin A.
2. It stores vitamin B.
3. It changes vitamin K to prothrombin.

Heat Regulation.—This is the natural result of the many chemical activities with which the liver is concerned.

Detoxification Functions of the Liver

Detoxification is an extremely important function. Most of the blood from the digestive tract passes through the liver before reaching the general circulation. In the liver certain substances are returned to the intestine through the bile, other substances are passed on unchanged to the general

circulation, while other substances are modified chemically or detoxified in the liver.

The liver detoxifies poisons by several methods, such as the following:

Chemical Means.—The conjugation of poisons with:

1. Sulphuric acid, forming sulphates. Indican converted to indoxyl sulphate. Skatol converted to skatoxyl sulphate, et cetera.
2. Glucuronic acid, forming glucuronides. Phenol converted to phenol glucuronid.
3. Amino acids, such as glycine. Benzoic acid changed to hippuric acid.
4. Detoxification by oxidation, by reduction, by methylation and by acetylation. Morphine, strychnine and many other drugs are partially destroyed in the liver.

Reticulo-endothelial Activity.—Kupffer cells remove bacteria, foreign proteins, dyes, et cetera from the blood stream.

Excretion in Bile.—Many bacteria are taken from the blood stream and excreted through the bile into the intestine. Notably colon and typhoid bacilli, but also may other organisms which reach the liver through the portal or general circulation. Many chemicals are excreted unchanged by the bile.

Storage in the Liver.—Poisons are stored in the liver and then slowly released, thereby lessening their effect by dilution.

Blood Formation Functions of the Liver

1. The liver forms most plasma proteins, such as albumin, globulin, prothrombin and fibrinogen. Determines albumin-globulin ratio.
2. It makes prothrombin from vitamin K. Prothrombin + calcium = Thrombin. Thrombin + fibrinogen = clot. In obstructive jaundice absorption of fat soluble vitamin K is lessened or absent.
3. It stores ventriculin and iron.
4. Forms red blood cells in the embryo.

Classification of Tests for Hepatic Disease

The following outline lists, according to the liver function to be tested, the tests which have been proposed and studied. Many are only of academic interest, while those tests listed in italics have been shown to be of great practical clinical value. It is impractical and usually unnecessary to carry out more than a few of these functional tests on any one patient. The results of such tests should supplement other clinical study. Much confusion has resulted from failure to recognize that the liver has a large factor of safety. As much as 75 per cent of liver cells must be impaired to give positive liver function tests. On the other hand, the liver, according to Ivy, has great regenerative ability, in that following the removal of 70 per cent of the liver of rats and dogs, 90 per cent regeneration will occur in a few weeks.[5] Therefore, the early treatment of liver disease is most valuable.

A. *Tests of the Excretory Functions of the Liver.*

I. Formation and secretion of bile.

1. Secretion of bile salts.
   - (a) Estimation of bile salts in blood.
   - (b) Estimation of bile salts in bile.
2. Excretion of bilirubin.
   - (a) Tests for bilirubin in urine.
     - (1) *Foam Test.*
     - (2) *Harrison Spot Test.*
     - (3) Methylene blue test.

This test is easy to do and is of value in recording the amount of bile in the urine from day to day. However, it is not specific for bilirubin and, like the foam test, may be influenced by other urine pigment. Its reaction depends not on a chemical change but upon a color mixture, i.e., the blue of the reagent and the yellow of the urine produces a green color.

   - (b) Tests for, and estimation of, bilirubin in blood.
     - (1) *Serum Bilirubin Direct I' van den Bergh (Chole-Bilirubin).*
     - (2) *Total Serum Bilirubin Indirect T I' van den Bergh (Chole+ Hemo-Bilirubin).*

The significance of these tests has been previously discussed. They are not difficult to perform and can be done rapidly in any laboratory equipped with a photoelectric colorimeter. They should be done as one of the screening tests on all patients in whom liver disease (possibly subclinical) might be suspected.

   - (c) Icterus index.

This test has been of value in indicating the degree of jaundice, and in following the progress of such patients. It has the disadvantage of not indicating the two types of bilirubin, and it also may be influenced by other pigments, such as from blood hemolysis, vegetable pigments such as carotine, and by chemicals such as piric acid. It is a crude inaccurate method compared to the bilirubin estimation.

   - (d) Tests for, and estimation of, urobilinogen in urine.
     - (1) *Qualitative Ehrlich Aldehyde Urobilinogen Test.*
     - (2) *Wallace-Diamond Dilution Technique.*
     - (3) *Watson Quantitative Method.*
   - (e) Estimation of urobilinogen in feces.

The urine urobilinogen test is so simple that it should be done as one of the routine tests on all urine specimens. If the test is positive, a fairly accurate estimate of the amount can be obtained by the Wallace and Diamond[14] dilution technique. A positive test with a urine dilution of 1:30 or greater is regarded as abnormal. The quantitative method of Watson and associates[16] is more accurate. The urine secreted between the hours of 2:00 and 4:00 p.m. is used because it has been found that urobilinogen excretion is usually greatest at this time. It is best to do this estimation on three different days because of the variation in excretion. Values exceeding 2.5 Ehrlich units for a two-hour period are abnormal. When the urine is high in urobilinogen, it indicates hepato-cellular damage, or a marked blood destruction of some sort, the later of which usually can easily be ruled out. In liver disease the urine may at times show little or no urobilinogen. This occurs when the stool is being passed rapidly through the bowel and there is not time enough for urobilinogen formation, or when there is a reduction or absence of bilirubin in the bowel due to biliary obstruction. If there is complete biliary obstruction, there can be no urobilinogen formed and hence none in the urine. A fecal urobilinogen estimation helps in explaining and interpreting low urine findings in cases of obvious liver disease.

3. Excretion of inorganic salts in bile. Used in cases of surgical biliary drainage. Sodium chloride. Calcium.

II. Excretory loading tests.

1. Dye excretion.

(a) *Bromsulphthalein.*

This is one of the most useful of the liver function tests. It is however of no value when jaundice is present because of the similarity of colors in the serum. The adopted standard technique is the intravenous injection of 5 mg. of the dye per kilogram body weight, and the determination of the percentage remaining in the blood stream 45 minutes later.[8] The test is easy to do. The dye can be purchased in ampules ready for injection. The estimation of the remaining dye in the serum is done by means of a photo-electric colorimeter, or by color standards. Retention of more than 5 per cent of the dye is abnormal.

(b) Rose bengal.

(c) Phenoltetraiodophthalein.

(d) Phenoltetrachlorphthalein.

2. *Estimation of Serum Alkaline Phosphatase.*

Phosphatase in an enzyme formed in the bone marrow and in the intestinal mucosa. It is apparently mostly excreted in the bile after storage in the liver where it plays an important role in several liver metabolic functions, notably the changing of glycogen back to glucose for release into the blood stream. In a case of obstructive jaundice, yet with normal liver cells, the serum alkaline phosphatase is increased, over 10 Bodansky units is abnormal. In parenchymal liver disease the findings are below that figure. The test, therefore, is of great value in the differential diagnosis between hepato-cellular and obstructive jaundice, if done within the first three or four weeks of jaundice before liver damage has been produced. The test is time-consuming and technically difficult.

3. Porphyrin excretion in the urine. The urinary: fecal copro-porphyrin ratio.

4. Tyrosin tolerance test.

5. Sterobilin clearance test.

B. *Tests of the Metabolic Functions of the Liver.*

I. Carbohydrate metabolism.

1. *Oral Galactose Tolerance Test.*

This is easy to do. The fasting patient is given 40 gm. of galactose in 250 c.c. of water by mouth. All the urine secreted during the following five hours is collected and a quantitative sugar estimation is done. An excretion of over 2 gm. of sugar during this five hours is abnormal. This test is usually positive during the first few weeks of parenchymal jaundice but not in early obstructive jaundice. The results are variable in chronic liver disease because of the high margin of liver reserve and its great ability to regenerate. The test is of great value in the differential diagnosis between hepato-cellular and obstructive jaundice if done in the first three or four weeks before liver damage has occurred in cases of biliary obstruction.

2. Intravenous galactose tolerance test.

A sensitive test, but has the technical disadvantage of requiring the removal of the serum glucose by fermentation before the galactose is estimated.

3. Fasting blood glucose, and blood glucose curve.

4. Fructose tolerance test.

II. Protein metabolism.

1. *Detection of Amino Acids in Urine.*

One of the functions of the liver is the conversion of amino acids to urea; hence, in case of liver disease one would expect an increase of amino acids in the blood and urine. However, this is only found in very severe liver disease such as acute yellow atrophy, in which case the crystals of leucine and tyrosine can often be found in the urine.

2. Blood urea.

3. Blood uric acid.

III. Fat metabolism.

1. *Estimation of Total Blood Cholesterol and Ester: Total Ratio.*

The total blood cholesterol is increased in most cases of obstructive jaundice. Over 220 mg. per c.c. is abnormal. In hepato-cellular jaundice the figure is lower because of disturbed liver function. The cholesterol ester fraction should not be less than 60 per cent of the total, below this figure is indication that the liver is failing in its function of combining cholesterol with fatty acids to form esters.

2. Fat tolerance tests, oral and intravenous.

IV. Water metabolism.

The liver acts as a reservoir for water and blood and helps to maintain blood volume. As a test of this function the patient is given 1,000 c.c. of water on an empty stomach.[1] The specific gravity of the urine is ascertained

just before giving the fluid. The patient voids every hour and the urine specific gravity is recorded. With a normal liver the specific gravity returns to that of the fasting state in four hours. With metastatic growths and other severe liver disease, there is considerable delay in a return to the original concentrated urine, because of the inability of the liver to hold water. Nephritis must be excluded by previous clinical and urine examination.

V. Vitamin metabolism.

C. *Tests of the Detoxification Functions of the Liver.*

I. Hippuric acid synthesis from sodium benzoate.

1. *Oral Hippuric Acid Test.*

6.0 gm. of sodium benzoate is given by mouth fasting, followed by 300 c.c. of water. The amount of hippuric acid excreted in the urine during the following four hours is estimated. Under 3 gm. is abnormal. The disadvantage of this oral test is the variability of absorption of the sodium benzoate, and the occasional occurance of nausea and vomiting.

2. Intravenous Hippuric Acid Test.

An ampule containing 1.77 gm. of sodium benzoate in solution is given intravenously. Under 1 gm. of hippuric acid secreted in the urine during the following one hour is considered abnormal. The estimation of the hippuric acid in the urine is done by the same method, devised by Quick,[12] in both the oral and intravenous methods. The process is rather time-consuming and therefore costly. Both tests are, however, fairly sensitive and reliable. In both of these tests the output of hippuric acid depends somewhat upon the output of water. It is advisable to inject 1 c.c. phenolsulfonephthalein solution with the sodium benzoate and do a simultaneous kidney function test.

II. Cinchophen test.

III. Glucuronic acid test.[13]

D. *Tests of the Blood Formation Functions of the Liver.*

I. Erythrocytes.

In severe liver disease there may be a macrocytic hypochromic anemia.

II. Serum proteins.

In severe parenchymal disease the serum albumin is usually reduced and the serum globulin increased. The proteins probably are also changed chemically. The cephalin cholesterol flocculation test and the thymol turbidity and flocculation tests are thought to be due to changes in the gamma and beta globulin fractions respectfully. They are not a measure of liver function but rather an indication of liver cell damage.

1. *Total Serum Protein. Normal* = 6 to 8 gm. per 100 c.c.
2. *Total Serum Albumin.* Normal = 4 to 5.2 gm. per 100 c.c.
3. *Total Serum Globulin.* Normal = 2 to 2.8 gm. per 100 c.c.
   A:G ratio = 1.5:1 to 3:1.
4. *Cehpalin Cholesterol Flocculation Test.*

This test, devised by Hanger[4] and further studied by Mateer[8] and other investigators,[2] is positive in a very high percentage of patients with early active parenchymal liver disease, and seldom gives a false positive reaction with careful technique. The reagent can now be purchased already prepared. The stock solution after preparation is stable for many months if kept on ice in the dark. An emulsion of the stock solution must be prepared daily however, which takes extra time; otherwise the test is easy to do. The degree of flocculation is read at twenty-four hours as zero to 4+. Anything 2+ or over is indicative of active parenchymal liver disease.

5. *Thymol Turbidity Test.*

This test, devised by Maclagan,[7] has about the same clinical application and value as the cephalin cholesterol, but is less liable to error, takes less time and is easier to do. Positive tests with two methods do not exactly parallel each other because the reactions are due to changes in different fractions or the serum protein. The degree of turbidity is read at thirty minutes by comparison with the Kingsbury-Clarke protein standards or in a photoelectric colorimeter. The turbidity units of 3.0 or more are abnormal. Neffe[10] has introduced another method of reading the reaction by allowing the same tests (after reading the turbidity at thirty minutes) to stand for twenty-four hours and then reading the flocculation in the tubes in terms of zero to 4+. The results follow closely the turbidity readings.

6. Takata-Ara reaction.
7. Colloidal gold reaction.
8. Magnesium chlorid test.
9. Formal-gel reaction.
10. Weltman coagulation band.
11. *Prothrombin Time.*

The liver makes prothrombin and fibrinogen. Prothrombin is made from absorbed vitamin K; therefore a low blood prothrombin time can be due either to liver parenchymal disease or to a failure to absorb vitamin K due to a lack of bile in the intestine (jaundice). The normal prothrombin time is taken as 70-100.

12. *Prothrombin Response Test.*

A prothrombin time is first done, and when found to be low, i.e., below 70, an injection of vitamin K is given on two successive days, and another prothrombin time is done on the third day; if the reading is below 70 it indicates that parenchymal liver disease is present. If the reading returns to normal, 70 or above, there is indication of a normal liver, and that the previous low reading was due to an obstructive jaundice.

13. *Blood fibrinogen.*

Tests are of little value because a reduction takes place only very late in liver disease.

Discussion

Most cases of cirrhosis of the liver are diagnosed in a late stage of the disease by the occurrence of a massive hemorrhage from esophageal varices, by the appearance of ascites, or by jaundice. It is highly desirable that some method be instituted for the detection of early hepatic impairment before

the development of extensive chronic hepatitis or cirrhosis. In the early subclinical stages of liver disease, the results of treatment have been found to be very good. This theme has been recently emphasized by Mateer and associates.[9]

Inasmuch as there are often no clinical signs or symptoms in early liver disease, and inasmuch as we now have a fairly good knowledge of the sensitivity and practical use of the various liver function tests, it is felt that certain of these tests should be included in the routine laboratory work of all internal medicine examinations in the office as well as the hospital, the other tests being reserved for special indications. Following is a grouping of the tests according to their indications.

Group I.—These tests should be included with other routine laboratory work such as the urinalysis, blood count, Kahn test, et cetera, in all examinations.

1. Urine bilirubin foam test. If questionable do the Harrison spot test.
2. Urine qualitative urobilinogen test.
3. Serum cephalin cholesterol flocculation test.
4. Serum thymol test.

These two latter tests can easily be done on serum obtained when the Kahn blood is taken.

Group II.—If any of the Group I tests are positive or if there are other clinical indications, these further tests should be done.

1. Urine quantitative urobilinogen. Watson technique, two hours, 2:00 to 4:00 p.m. urine on three successive days, or Wallace-Diamond dilution method.
2. Serum bilirubin, total quantitative direct and indirect.
3. Bromsulfalein. 5 mg. per kilogram body weight. Dye retention estimated at forty-five minutes.

Group III.—These tests are indicated for further liver study, when considerable hepatic damage is suspected.

1. Serum albumin and serum globulin. A:G ratio.
2. Oral hippuric acid test.

Group IV.—The tests in this group are of value and usually necessary in the early differentiation of hepato-cellular and obstructive jaundice.

1. Cephalin cholesterol flocculation. Positive only in hepato-cellular jaundice.
2. Thymol test. Positive only in hepato-cellular jaundice.
3. Urine urobilinogen. Increased amounts show diffuse hepato-cellular damage. Absence may be due to complete obstructive jaundice.
4. Serum bilirubin. Over 1.0 mg. per 100 c.c. indicates retention jaundice. If the direct one-minute bilirubin is over 0.2 mg. per 100 c.c., regurgitation or obstructive jaundice is shown.
5. Serum alkaline phosphatase. Normal or low in hepato-cellular, high (over 10 Bodansky units) in obstructive jaundice.
6. Blood prothrombin. If low (below 70) and does not return to 70 + after parenteral vitamin K, hepato-cellular damage is indicated; if it does go up to 70 +, obstructive jaundice is indicated.
7. Oral galactose tolerance test. Positive in hepato-cellular, negative in obstructive jaundice.
8. Oral hippuric acid test. Positive in hepato-cellular, negative in obstructive jaundice.

All of these tests may lose their differential diagnostic value in cases of obstructive jaundice of three or four weeks' duration, because of the secondary development of hepato-cellular damage.

Conclusions

The physiology of the liver and the function tests to detect liver abnormalities are now well enough understood to be more routinely used, not only in the study of manifest liver disease and jaundice cases but in the early detection of subclinical liver deficiencies, at which time medical treatment is of greatest value. Certain tests should be included in the routine laboratory work of all internal medicine examinations in the office as well as in the hospital.

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Argyrosis Following Prolonged Intranasal Medication with Argyrol

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THE INCIDENCE and danger of argyrosis were more strongly emphasized during the early part of this century when silver salts were popular as therapeutic agents. Nevertheless, there still remains the feeling that the administration of silver salts in small amounts over a long period of time is innocuous. We wish to review the literature pertaining to generalized argyrosis and also to present an example of this condition following the intermittent administration of argyrol intranasally for a period of twenty years.

Fourcroy[2] in 1791 made the first reference to argyrosis. Allen[1] in his report of a case of generalized argyrosis in 1906 stated that from the Middle Ages until the middle of the nineteenth century the number of cases increased, but in the second half of the nineteenth century this condition became uncommon as a result of undesirable reactions and the fact that silver salts were losing favor as therapeutic agents. In 1897 Crede again pointed out the beneficial effects of silver salts, and the drug again won popularity in the form of ointments and local antiseptics.

Gaul and Staud[3] collected thirteen cases of generalized argyrosis caused by organic silver preparations from 1914 to 1928. Between 1928 and 1935, twenty-seven cases have been reported. This condition is definitely on the increase, inasmuch as the manufacturers of organic preparations of silver state that there is no danger of skin reactions, and as a consequence, these drugs have been used more frequently. Silver arsphenamine, which was introduced in the treatment of neurosyphilis, has led to generalized argyrosis.[6]

Hill and Montgomery[4] reported sixty-eight cases of generalized argyrosis seen at the Mayo Clinic from 1915 to 1939. Females predominated in a ratio of seven to four. Two-thirds of the patients were in the age groups of from forty to sixty years. The pathological pigmentation of the skin, as detected by the patient or the relatives, varied from six months to fifteen years from the time the silver was first used. In a majority of the cases, the pigmentation appeared only after the silver had been employed for a period of two to three years. Fifty per cent of the patients had used silver for gastrointestinal disturbances, 33 per cent for diseases of the upper respiratory tract, and 17 per cent had been treated for vaginal and urethral pathologic conditions.

Stillians[7] lists the following causes of argyrosis:

Causes of argyria in industry:

(1) Sucking silver solutions into the mouth in the effort to suck them into glass beads to coat the inner surface. (This corresponds to item 9.)
(2) Breathing silver dust.
(3) Putting fingers contaminated with silver dust into the mouth.

Causes of argyria in therapy:

(4) Absorbing silver from dental fillings dissolved by electric currents generated in the mouth.
(5) Absorbing silver from disintegrating suture or tracheotomy tubes.
(6) Taking silver preparations by mouth for local effect on the gastrointestinal tract for an imagined general effect.
(7) Irrigating body cavities with silver solutions.
(8) Administering silver-containing drugs intravenously.
(9) Accidentally swallowing solutions used locally in the mouth, nose, throat, or conjunctival sac.

Biopsy studies by direct illumination and dark-field methods have shown "that the silver is not deposited in the epidermis but is seen in relation to the elastic fibers in the cutis, to the membrana propria of the sweat glands, to the connective tissue sheaths about the sebaceous glands and hair follicles, and to the cutaneous vessels, muscles and nerves. Granules of silver are seen most frequently about the sweat glands and in the papillary bodies at the so-called subdermal or subepithelial line."[4]

The differential diagnosis in the case of generalized argyrosis includes the following conditions: congenital cardiac lesions, pulmonary lesions, Addison's disease, hemochromatosis, sulfhemoglobinemia, pigmentation due to bismuth, methemoglobinemia, and pigmentation from mercury, arsenic and gold. The diagnosis of generalized argyrosis is made from the history of prolonged use of silver salts and from the resulting bluish discoloration of the parts of the skin exposed to the light, as compared to the ashen gray color of the remainder of the skin. The intradermal injection of a mixture

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of 1 per cent potassium ferricyanide and 6 per cent sodium thiosulfate in distilled water will result in a light spot at the point of injection.[7] This test, however, is negative when bismuth pigmentation complicates argyrosis.[5] Biopsy study of the skin by direct illumination and dark-field methods is the one of choice in arriving at the diagnosis. Spectrophotometric studies may be indicated, especially when bismuth pigmentation complicates the picture.[4]

Stillians and Lawless[8] have reported gratifying results in the treatment of this condition by injecing intradermally a photographic reducing solution which contains 1 per cent potassium ferricyanide and 6 per cent sodium thiosulfate. After this material was injected, a light area nearly as pale as the normal skin was noted. By repeated injections large areas of abnormal pigmentation may be cleared. The lower eyelid for the most part remained refractory to this type of treatment since the skin in that region is thin and the fluid which is injected does not come in proper contact with the silver deposit.

Case Report

The patient, a white woman of thirty-nine, was first seen in the outpatient department on April 3, 1946, at which time she complained of a bluish discoloration of the skin which she had noticed for a period of approximately one year. In 1923 she had what she termed "bronchial trouble" which persisted for a period of twenty years. When the "bronchial trouble" first began she was advised to use 10 per cent argyrol to clear the secretions from her nose and throat. The patient was unable to state how frequently or how much of this medicine she instilled into her nose in a given day; however, she did continue to use this medicine intermittently over a fifteen-year period.

About eight years ago, she was advised by a second physician to continue the use of 10 per cent argyrol "since her nose was the site of all her trouble." She used argyrol daily, morning and night, for approximately two years. During this latter period of time she stated that she put a dropper full in each nostril, after which the secretions would fall into her throat and were easily coughed up. Over this period of two years she felt that she had used an ounce of argyrol approximately every ten days to two weeks.

In 1940 she began to use argyrol at occasional intervals, and since 1943 she had ceased the use of any silver salts.

Physical examination revealed an undernourished, chronically ill, white woman whose temperature was 98.6° and pulse 80. She was 5 feet 6½ inches tall and weighed 97 pounds.

Dental examination revealed upper and lower partial plates. In the neck there was a half-dollar sized nodule at the right lateral aspect which rose and fell upon swallowing. The dorsal spine showed a dextro-scoliosis. There was a marked slate blue appearance of the face, lips, buccal mucosa, chest wall, abdomen and back.

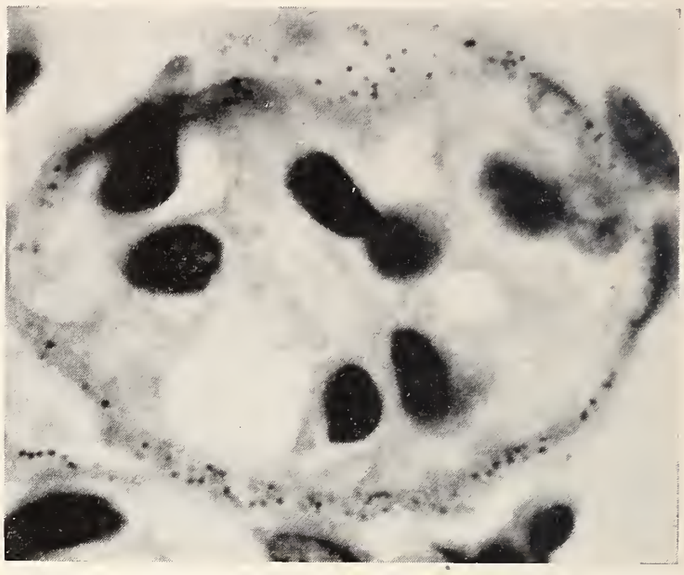


Fig. 1. Photomicrograph of skin (x1300) showing round silver granules in tunica propria and basket cells of sweat glands. These granules were seen also in walls of small blood vessels and in the corium immediately beneath the epidermis.

The legs and thighs also presented a slate blue color but of less intensity than the areas previously described. The remainder of the physical examination was negative.

Chest x-ray revealed a severe dextro-scoliosis of the dorsal spine with consistent deformity of the bony thorax. The only positive laboratory finding was a red blood cell count of 3,620,000.

On July 7, 1946, a skin biopsy was performed, and a piece of tissue was removed from the upper part of the right thigh. The pathological report* revealed the following: "A large number of silver granules were found in the basket cell layer and tunica propria of the sweat glands, in the blood vessel walls, and in the corium immediately beneath the epidermis. A lesser number were seen scattered through the corium. No granules were seen in epithelial cells of the epidermis and lining of sweat glands. The silver granules were demonstrated as fine, spherical, black bodies under H & E stain and simple contrast stains, and as highly refractile spherical bodies under dark-field examination.

Pathological diagnosis: Argyrosis.

The clinical diagnoses were generalized argyrosis, undernutrition, nontoxic adenoma of thyroid and dextroscoliosis of the thoracic spine.

Summary and Conclusion

A review of the literature pertaining to generalized argyrosis has been presented. This included a discussion of the history, clinical data, methods of acquiring this skin condition, histology, differential

(Continued on Page 1240)

*Pathological report was made by Dr. C. I. Owen, head of the Department of Pathology, Riverside Clinic and Grace Hospital, Detroit, Michigan.

External Duodenal Fistula

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DUODENAL FISTULA is a rare but serious complication of operations on the upper gastrointestinal tract, extrahepatic biliary system, and right kidney. Treatment has never been very satisfactory. Early in the present century, attempts were made to close the hole in the duodenum by direct surgical attack as soon as its presence was recognized. Technical difficulties encountered were great, and almost all the patients died. Because the results were so poor, indirect methods of approach next were attempted. Gastroenterostomy, gastroenterostomy with pyloric exclusion, and jejunostomy were tried, in an effort to side-track part of the duodenal stream and to enable the patient to be fed. However, the mortality continued to be appallingly high.

In 1921 Erdman[7] reported the successful treatment of a case by conservative measures, including continuous suction applied to the depths of the fistula. Cameron[4] and Colp[5] independently reviewed the literature in 1923 and advocated that radical treatment, including simple closure, gastroenterostomy, and gastroenterostomy plus pyloric exclusion, should be abandoned; that conservative measures, including continuous suction through the fistulous tract should be employed; and that this treatment should be supplemented by jejunostomy for feeding purposes. Colp also pointed out that those fistulas which occurred following operations on the gall bladder and bile ducts were much less serious than other types, carrying a mortality of only 15 per cent. Because the results were better, the conservative type of regime soon came to be accepted as standard treatment for postoperative duodenal fistula. In the ensuing years, methods of local treatment of the fistula itself, including suction, protection of the skin, and the composition of irrigating fluids supplementing suction, were considered to be of paramount importance.[8,9,11,12,18,19,20] Recently greater emphasis also has been placed on adequate nutrition of the patient.[14,17]

In 1938 Bartlett and Lowell reviewed 130 cases of postoperative duodenal fistula reported up to that time and added twelve cases of their own from the Massachusetts General Hospital records.[1] Analysis of their figures led them to confirm the opinion that conservative treatment with jejunostomy was best. Curiously enough, however, of their own twelve cases, seven died (58 per cent). Their explanation was that jejunostomy was done far too late in most of the cases. Since 1938, various single reports of postoperative fistulas successfully treated by conservative measures have appeared.[6,10,14,15,16,17] Doubtless the many unsuccessfully managed ones have not found their way into print. In 1944 Schneider[13] reviewed the literature on duodenal fistula occurring after operation on the right kidney, and added four case reports from the Charity Hospital at New Orleans. The mortality was 55 per cent in nineteen cases treated conservatively and 50 per cent in fourteen cases treated by operation. It is suggested that in view of this persistent high mortality, methods of treatment could with profit be critically re-evaluated.

Case Report

A. W., colored male, aged sixty-one, was admitted to Detroit Receiving Hospital June 30, 1947, complaining of painless hematuria. A diagnosis of tumor of the right kidney was made and nephrectomy was performed on July 21, 1947, through an incision in the right loin. The mass evidently extended outside the renal pelvis and adjacent portion of the ureter, so that the operation was quite difficult. Hemorrhage was troublesome, and the peritoneum was opened in one area. It was thought that some of the tumor was probably left behind. The gross specimen showed a large hemorrhagic mass replacing the pelvis and upper ureter as well as almost all of the kidney itself. Microscopic diagnosis was papillary carcinoma of the kidney extensively invading the renal parenchyma. Postoperatively there was a moderate amount of fever, thought due to bronchopneumonia. On July 31, 1947, ten days after operation, the wound broke open and profuse drainage of bile-stained fluid ensued. A diagnosis of duodenal fistula was made without difficulty.

During the next few days, continuous suction was applied to the fistula through a catheter with multiple perforations, and continuous gastric suction by means of a Levine tube also was employed. The patient was given repeated blood transfusions and as much as 6,000 c.c. of parenteral fluids (glucose, saline, amigen, vitamins, et cetera) per day, but in spite of this, the fistula, which was draining some 1,500 c.c. of fluid daily, increased rapidly in size, with extensive undermining of the skin, and the patient rapidly went downhill. He appeared dehydrated and toxic, and by August 6, 1947, was semicomatose. It seemed certain that death would soon follow. For this reason on August 6, 1947 (seventeen days

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after nephrectomy and one week after the fistula had appeared), a pyloric exclusion operation was performed without attempting to disturb the actual site of the fistula (Fig. 1). The operation was done under local anesthesia with bilateral intercostal block and splanchnic infiltration, and the patient appeared to tolerate the procedure satisfactorily.

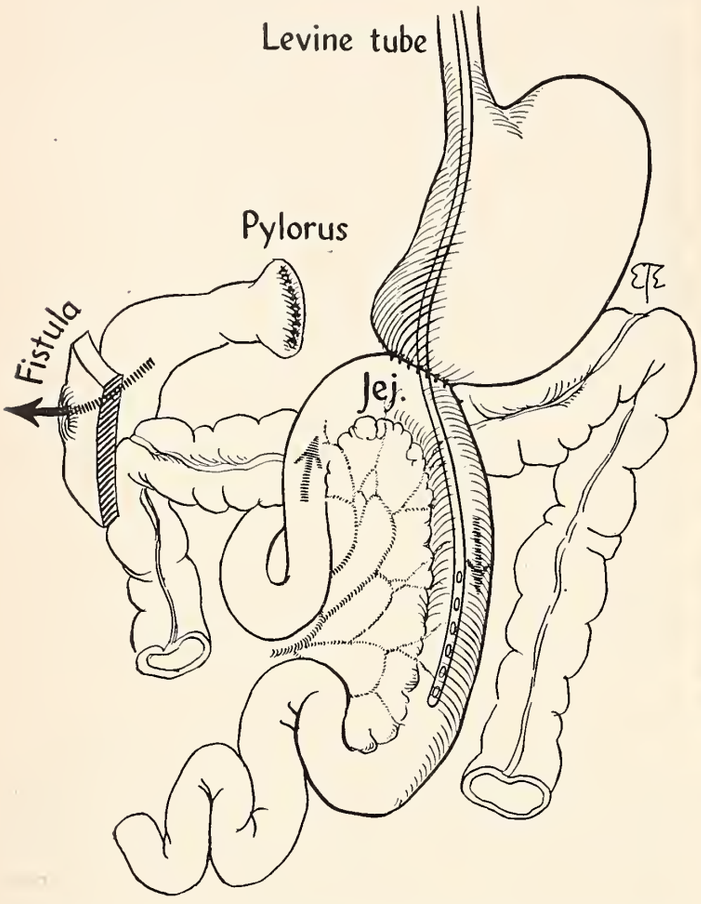


Fig. 1. Drawing of operation. The stomach was cut across a few centimeters proximal to the pylorus, and the distal end turned in. A long anterior gastrojejunostomy was then performed without the use of clamps. The indwelling Levine tube was passed well down into the distal loop so that it could be used subsequently for feeding purposes. The fistula itself was not disturbed.

The operation was followed by acidosis (duodenal contents still were lost in the fistulous discharge but gastric hydrochloric acid was now conserved to the body). The acidosis was treated by the intravenous administration of appropriate amounts of one-sixth molar sodium lactate. The other measures that had been employed preoperatively also were continued, and gradual improvement in the patient's condition occurred. Drainage from the fistula decreased in amount, and the large necrotic undermined sloughing area about it rapidly healed in, so that by September 3, 1947, a Foley catheter inserted into the fistula would stop the drainage completely. Improvement continued, gain in weight occurred, and the fistula finally closed October 19, 1947, two and one-half months after its appearance. For a short time the patient remained in fairly good health. Soon, however, he began to complain of symptoms suggestive of extensive metastatic spread of the renal carcinoma. Progress was then rapidly downhill, and he died December 3, 1947. Autopsy confirmed the clinical impression of extensive intra-abdominal carcinomatosis, and showed that the primary lesion had ulcerated into the second part of the duodenum. In spite of this, the fistula (which clinically had remained closed) was found to be completely obliterated by well-healed fibrous tissue.



Fig. 2. Postoperative barium series showing well functioning gastroenterostomy stoma.

Comment

Berg first performed gastroenterostomy with pyloric exclusion for duodenal fistula in 1902, and reported a second case so treated in 1907.[2] He tied the pyloric antrum with tape and did a gastrojejunostomy, then later completed the pyloric exclusion in one of his cases. Unfortunately both patients died. The procedure was tried by others, but cases reported up to 1923 suffered the prohibitive mortality of 85 per cent[5] and the operation was abandoned. Bohrer and Milici, after again reviewing the literature in 1931,[3] decided that conservative treatment should be employed for acute or early cases, and that operative measures including pyloric exclusion should be considered for those chronic cases who had recovered from the initial disturbance but with the fistula still present. To our knowledge no further consideration had been given the procedure of pyloric exclusion for this condition.

In a very limited personal experience, we have been impressed by the rapidity with which healthy

persons suffering from duodenal fistula may go downhill and die, especially following operations on the right kidney, even though every effort is made to maintain fluid, electrolyte and nitrogen balance, as well as to keep the wound in good condition. The case presented in this report is a good example. Progress was rapidly downhill until, under local anesthesia, pyloric exclusion was performed. The operation seemed to have no deleterious effect, and was followed by slow but continued improvement.

While this case presents nothing new so far as approach to the problem of duodenal fistula is concerned, it indicates that a simple exclusion operation which seems to have been abandoned does have merit. Our reason for performing this operation in the treatment of duodenal fistula is based on a consideration of the causes of death resulting from duodenal fistula and prevention as far as is possible. It is a well-known fact that disastrous difficulties are associated with duodenal fistula. The first and most rapidly serious of these is the great loss of fluid through the fistula. Not only is there a tendency for bile, pancreatic juice and succus entericus to be lost, but fluids taken by mouth likewise tend to escape through the fistula. Fluids taken by mouth not only tend to be lost through the fistula but actually stimulate the loss of other fluids from the duodenum. The second important consideration in the care of a patient with duodenal fistula is the maintenance of nutrition. It is exceedingly difficult to maintain nutrition in a patient with duodenal fistula because of the loss of material through the fistula, even though parenteral feeding is pushed to the maximum. The third important problem has to do with the care of the wound, and it is quite common for the tissues about the fistulous tract to become markedly inflamed and necrotic despite the most careful treatment. The exclusion operation sidetracks a large mass of material away from the involved duodenum, decreases the amount of fluid lost through the opening, and permits feeding by mouth.

It must be recognized that patients who have had duodenal fistula for any length of time do not stand operation well, and therefore the operation to accomplish diversion of the gastrointestinal content must be as simple as possible. No attempt ought to be made to resect any portion of the stomach, and the procedure ought to entail very little more trauma to the patient than that associated with a jejunostomy for feeding. It is on the basis of these fundamental considerations that we consider the exclusion operation important in the treatment of duodenal fistula despite the disheartening results that have been reported by earlier authors.

Conclusion

Gastroenterostomy with pyloric exclusion is a simple procedure easily performed under local anesthesia. It should be considered for all patients suffering from postoperative duodenal fistula who do not show an immediate favorable response to more conservative measures.

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MSMS

TUBERCULOSIS PROGRESS

The medical profession can well be proud of its contribution to the voluntary tuberculosis movement. In turn, the tuberculosis associations devoutly hope that if it were possible to ask these departed pioneers, "How are we doing, Doctor?" their answer would be, "Fine."

The Rh Factor

Case History and Evaluation by a General Practitioner

By E. A. Bicknell, M.D.
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MRS. V., white, aged thirty-nine, was first seen by me on April 28, 1947, when she stated that her last menstrual period had occurred on February 18, 1947. In January, 1944, she had given birth, with no difficulty, to a live baby girl (breech presentation) weighing 7 pounds 7 ounces. Both had remained well. There was no other significant past history. Examination revealed a uterus about eight weeks pregnant. There was endocervicitis with erosion. Some nausea was present and persisted until the thirteenth week. Her blood, urine, blood pressure and weight remained normal throughout the pregnancy. Expected date of birth was November 27, 1947.

On August 22, 1947, her Rh factor was reported negative. On September 9, her husband, aged forty-three, was reported to be Rh positive. I told them their blood was such that some effect on the mother or the baby might possibly be produced, but I minimized this and assured Mrs. V. that she might have several pregnancies without any trouble, and that I personally had never encountered any trouble from the Rh factor in twenty-five years of general practice. She was still apprehensive, however, and even more so was her Maltese husband, who had never consulted me and whom I believed to be in perfect health. Both were devout Catholics.

At her eighth month examination Mrs. V. was reassured and told her baby was in a head presentation, which should allow a much easier delivery than her first. She was instructed to report once a week and was told that a medical induction would be instituted if she had not delivered by term.

Everything went well until her due date, November 27, when I was called to her home to see her husband, who had fainted and was pale and pulseless, with no recordable blood pressure. A history of his having had a gastrointestional hemorrhage five years earlier was obtained. This had never been accurately diagnosed; no x-ray had been taken, but he had been told that he had a bleeding peptic ulcer. For the present emergency, morphine, gr. ¼, was given, and he was carried by ambulance to the hospital and transfused with 500 c.c. of blood.

Mrs. V. was told to report for medical induction, but because of her husband's illness she failed to comply. Mr. V.'s anxiety for his wife was unabated; he continued to bleed, and on December 2, his red blood cell count was 2,070,000 with a hemoglobin of 48 per cent, in spite of his having received by then 1,500 c.c. of blood. Mrs. V. still refused to do as recommended because of her husband's condition. (Thus I was caught in a maelstrom, enmeshed in a new type of vicious circle).

Not till December 6, at 6:00 a.m. did she call. At that time she had had a frank hemorrhage from a premature separation of the placenta. She was hospitalized and cross-matched with Rh-negative blood. She had no labor pains. While I waited expectantly, her bleeding lessened and her condition remained good. I mulled over the idea of a cesarian section and endeavored to locate a consultant on the obstetric staff for help. Fortunately, labor started spontaneously at 9:00 a.m., and at 10:00 a.m. under light nitrous oxide, oxygen anesthesia, she gave birth to an 8 pound 3½ ounce boy. An episiotomy was done while crowining, and blood was carefully conserved.

The baby cried at once and was never anoxic. The cord was wrapped twice around his neck, but it slipped over the head easily. There was a complete knot in the cord, but fortunately not a tight one. The placenta was a battledore type, about twice the normal size, with ten definite infarcts. The mother's blood loss was not excessive. The baby's blood studies showed him to be Rh positive, with a red blood cell count of 4,630,000 and a white blood count of 12,650. The differential count showed 64 per cent polymorphonuclear cells (63 filamented, 1 non-filamented), 36 per cent lymphocytic, 2 per cent normoblasts, and 10 per cent reticulocytes. Coagulation time was 3½ minutes. There was no clinical jaundice. Hemoglobin was 19 gm. This was checked daily and was never lower. When the baby left the hospital on the seventh postpartum day, his red cell count was 5,660,000 and his hemoglobin was 19 gm.

The mother's course was uneventful except for a temperature of 100.4° on the fourth postpartum day when her breasts were engorged. She was ambulatory on the first postpartum day.

The husband stopped bleeding promptly, and his red blood cell count rose to 3,500,000 and his hemoglobin to 11.4 gm. on the fifth postpartum day.

They all went home at the same time—the father by ambulance for further bed rest and care prior to x-ray examination and possible operation. On January 2, 1948, his hemoglobin was 14 gm. and red blood count 4,020,000. On the twelfth postpartum day, while at home, Mrs. V. developed a phlebothrombosis of the pelvic veins in spite of early ambulation. This I attributed to subinvolution of a very large firm uterus pressing on veins and retarding the blood flow. With rehospitalization, administration of heparin and dicoumarol, she recovered promptly and soon was able to resume her household duties.

Certain questions came to me while caring for this family. Is it necessary to test every pregnant woman for the Rh. factor? Yes. We must be forewarned to be forearmed. I believe every woman who has been sensitized by a previous pregnancy or transfusion should be checked, remembering that a pregnancy terminated accidentally or deliberately may be purposely hidden, or an injection of blood or serum may be easily forgotten or even unknown.

How about the husband? If the wife is negative, he should be checked to determine, if possible,

whether he is a homozygous or heterozygous Rh-positive person. The Rh factor in children of heterozygous fathers should be ascertained to help assay the status of the mother. We must also remember that a homozygous Rh-positive husband with an Rh-negative wife may not necessarily be the father of the child. Such cases have been reported by Levine.[2]

Need the antibodies be repeatedly checked for a rise in titre? I asked several obstetricians what they did about this. They all said they checked them. When I asked why, they answered similiarly that the patients expected it, and they wanted to get some idea about what was going on; but they all admitted that the babies' condition at delivery did not necessarily tally with findings.

It is well established by Levine[2] and others that the effect of a previous Rh-positive transfusion on these women is devastating. They rarely have normal babies, often aborting very early in the first pregnancy. Aside from these cases which are always extremely grave, the others are very variable. One check of the mother's blood for the titre of the antibodies should give the ordinary general practitioner or obstetrician adequate information.

There is no way I know for testing the threshold of the placental barrier before the baby's birth.

A.R.N., in the adjoining bed to Mrs. V., volunteered the following story: She was a para II, not sensitized for her first delivery, which had been uneventful. She declined to have an Rh test done early in her second pregnancy because she knew she would worry. Similarly, she didn't want to know if she had a rising titre. She was tested at eight and one-half months and was found to be Rh-positive. Her reluctance to be tested early was prompted by a case of a friend, a nurse, who was pregnant. Her friend's first confinement had been normal. Between the first and last pregnancies there had been three spontaneous abortions. An Rh test done at three months in her last pregnancy was negative; her husband was positive. She insisted that her Rh test be repeated, and worried constantly when it was reported still negative. The antibody check at eight months showed a rising titre, and she was frantic. Labor was induced one week before term, and she had a normal delivery of a baby boy.

These repeated tests unduly alarm the patient and are evidence of our increasing use of laboratory tests of little clinical or practical value. I feel sure that many patients, especially if they understood thoroughly the Rh story, would prefer to use this money to apply on the layette or the medical fee. (This is the type of work that some of the proponents of socialized medicine might advocate.) The general practitioner with a sympathetic understanding of his patient's basic emotion and economic status is loathe to alarm them or to waste their money on such barren projects. I find many men intrigued with this type of test, which Time, the Great Revealer, often proves worthless. Large teaching institutions, I feel, should conduct this type of research. The priceless ingredients of a clinician are his honesty and integrity and the ability to be more interested in his patients than their diseases. Every young Canadian medical student was taught to revere and follow the precepts of our illustrious doctor, the late Sir William Osler, who possessed the "human touch" and an understanding of the art of medicine such as few ever have. We can all learn from his teaching.

Need the family be warned about the Rh incombatability? I feel we are guilty of pernicious practice and malicious mischief in even warning prospective parents ever so gently. What is to be gained by the knowledge that the "Sword of Damocles" is suspended over the head of their unborn child and the expectant mother? No matter how casual we may be, the lurid details of premature delivery, maternal hemorrhage, kernicterus, icterus gravis, fetal hydrops, and erythroblastosis fetalis are depicted in all their sinister and gruesome aspects in many current periodicals. These terms alone frighten most people. Mr. V. revealed that he had not worried unduly until he read a Sunday supplement describing these dread possibilities. What but constant queries and harassment are to be gained by the physician who alarms a family with this impending disaster—for such it must seem to many apprehensive people. How many physicians themselves can carry, with equanimity, the emotional strain of suspected malignancy, et cetera? We still have to await the results and treat our patients accordingly.

Premature induction of labor has been largely abandoned—prematurity being the greater of two evils.

I have passed through the era of exsanguination-transfusion treatment for burns, and have stood wide-eyed while Dr. William Robertson (long since

deceased), of the Toronto Sick Children's Hospital, employed the current treatment of bleeding a baby white and then substituting a reasonable facsimile of its life's blood. In 1925, Dr. Hart of Ontario, Canada, did this for one case of erythroblastosis, on the third postpartum day. The child lived but showed mental changes which may have had an anoxic basis. Probably for this reason, and the fact that the Rh factor was not known at that time, it was not repeated. Wallerstein[3] believes substitution transfusions are indicated in the desperately ill babies. They should only be done for specific indications, and by personnel thoroughly familiar with the procedure. I shudder to think of this being done routinely, for inadequate reasons, by unqualified people. This procedure was on display at the Interim Session at Cleveland in January, 1948, at the sessions expressly given for general practitioners. It recommended withdrawal of blood from the sagittal sinuses, radial artery and umbilical veins, in that order. It seemed very drastic to me. I argued rather vehemently with Dr. Wallerstein about the merits of this substitution transfusion instead of the standard transfusion. He inferred that some toxin was being removed which might prevent kernicterus, et cetera, while I claimed there was no proof of this; that his series was not run parallel, and was too insignificant to have statistical value—thirty cases in all, with only nineteen under optimal conditions. I contended that nothing had been shown but an anemia, and that prompt replacement therapy, continued as needed, would fill the needs. Bilirubin, or jaundice, doesn't poison cases of obliteration of bile ducts or hemolytic anemias. I feel that the anemia and the incidental anoxia of labor supplement one another. We can make gains by stopping premedication, lessening anesthesia (local is fine), and using oxygen freely before and after delivery. Animals have been shown to have a great ability to stand anoxia at birth and for about forty-eight hours afterward. However, they lose this ability rapidly, and by the end of a week are as bad off as the adults.

Any damage to the brain prior to birth is irreversible. Some infants are born dead, and a few are on the brink and may be salvaged by the doctors being prepared for prompt action at delivery. But why should we exsanguinate? That might be the final straw. Until someone shows me that there are toxins present, I will continue to believe anoxia is the more logical cause. Dr. John Wilson, professor of pediatrics at Ann Arbor, in a personal communication, has stated that no real scientific proof for the need of exsanguination-transfusion has been shown; he also felt it was far too drastic for present indications.

When nothing but confusion and anxiety, possibly of a severe degree, are to be gained by telling the patients of their danger, a discrete silence, assurance that their types are not serious, by not divulging that the father's test was positive (a little white lie), may do as much to maintain their confidence as similar justifiable deception in certain cases of malignancy. If possible, a relative, less intimately involved, or a friend, may be told of the situation, to save the doctor future embarrassment.

I am sure many of us are guilty of glossing over the moral issue, which is of great importance to many people, especially our Catholic friends. This has been ably presented in a paper by Father Schwitalla and Dr. Donald Kamp.[1] The Catholic church brooks no interference with the laws of God and Nature, either by avoiding or terminating pregnancy because of Rh incompatibility. Levine,[2] at the Interim Session, stressed the serious status of the wife, sensitized by prior Rh-positive transfusion, and advocated among other things, artificial insemination by Rh-negative sires, avoidance of pregnancy, interruption of pregnancy, abortion, et cetera. These procedures will never be adopted by Catholic physicians, or permitted in Catholic hospitals; and I believe this should be stated when these things are recommended. Levine also advocated substitution transfusions.

Conclusion

Fear of the Rh factor, and all that it implies, nearly cost me the life of this prospective father. I personally felt a very grave responsibility for my role in this episode, and I can't help but feel that the undue anxiety of the whole ordeal fostered the re-activation of this quiescent lesion, which might never otherwise have occurred. I will never again permit either my patients or myself to be the victims of such a situation.

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Concurrent Obstructive Jaundice and Familial Hemolytic Icterus

Report of a Case Requiring Priority Surgical Treatment for Obstruction

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WHILE THERE IS an associated cholelithiasis found in 60-70 per cent of cases of familial hemolytic icterus,[2,4,7] Horne[2] found the literature relatively free of articles reporting cases or emphasizing the importance of this condition in considering hemolytic icterus. A recent review of the literature disclosed several reports[1-7] emphasizing the importance of recognizing the coexistence of these conditions, but all deal primarily with the accepted treatment of the hemolytic icterus by splenectomy, with the cholelithiasis receiving secondary consideration, usually at a later operation or in a few cases in a one-stage procedure. McLaughlin, Sharpe, and Cunningham[4] state that it is unwise to deal with the existent biliary pathology as the primary surgical procedure, except in those rare instances in which increasing or unrelieved obstructive jaundice develops as a result of common bile duct obstruction or pain from calculi demands immediate surgical relief. They quote Pemberton and Lawrence as stating that occasionally the biliary lesion should be attacked first, but that these cases are very rare. It is the purpose of this paper to present such a case in which the obstructive symptoms were given primary consideration over the basic condition, operation for the correction of which was deferred. As stated, this is at odds with the usual consideration of the problem. While Pemberton[7] points out that, of his series of 118 cases in which splenectomy was performed for hemolytic icterus, twenty-three had had previous surgery on the biliary tract, he appears to be critical of the original operators for having done so. Apparently he regards the basic disease as having gone undiagnosed. While it is not within the scope of this paper to present a detailed discussion of familial hemlytic icterus (congenital hemolytic jaundice), the principal features are briefly reviewed for evaluation of the pertinent findings in this case. This is a hereditary hemolytic disease affecting primarily the spleen and secondarily the liver. It is characterized by anemia, acholuric jaundice (unaltered stools and urine), splenomegaly, spherocytosis, microcytosis, increased fragility, and active regeneration of the erythrocytes. The disease is characterized by recurrent crises with malaise, abdominal pain, fever, increased size of the spleen, deepening of the jaundice and increased anemia. These are not uncommonly mistaken for biliary colic. There is characteristic absence of itching, a delayed (indirect) Van den Bergh reaction, and the icteric index while elevated, rarely exceeds 30 in the uncomplicated picture. As previously stated there is an associated cholelithiasis found in 60-70 per cent of the cases.[2,4,7]

Report of a Case

The patient, first seen by one of us (HMB) on October 14, 1947, was a thirty-five-year-old unmarried white woman with a profound jaundice which she stated had come on over night. On the day before (October 13) she had had two attacks of epigastric pain which radiated through to the back. These were quite severe, lasted about thirty minutes, and were relieved with soda. They were typical of many previous attacks which had occurred since childhood. She had never required hypodermic injections for relief nor had she been frankly jaundiced, although her complexion and sclerae had been noted to be "muddy." The previous seven years had been relatively free of these episodes, but during the immediately preceding six weeks she had had five of them. With the exception of these acute episodes she had been subject to no gastrointestinal symptoms. Fried and fatty foods and pickles and all things sour were avoided, because it was noted abstinence seemed to lessen the frequency of the attacks. At the age of two it was stated patient had "spasms" caused by sour pickles. About ten years previously she had been advised her "bile needed thinning." She had never noted any previous jaundice or clay-colored stools, and stated that her urine was now dark for the first time. The family history was significant in that while there was no history of jaundice, gall bladder, or liver disease on the father's side, the mother had died at age fifty-four with jaundice, "dropsy," and pulmonary edema after a lifetime of intermittent attacks of painless jaundice. The maternal grandfather died with jaundice at age thirty-eight, and of the mother's five siblings, four had a history of jaundice or biliary disease. Of their children, five likewise have had symptoms, including one who had had a splenectomy. The patient had one brother who had recurrent jaundice throughout his lifetime and died at the age of twenty-one of an infection. Of five siblings living and considered to be in a good state of health, one brother has had one attack diagnosed as cholecystitis.

Physical examination revealed a well-developed, quite well-nourished, attractive, and well-groomed white woman

in no acute distress, but severely jaundiced to such a degree it appeared inconsistent with the history of such a recent onset. The only other finding of significance was a spleen which extended 4 cm. below the rib margin and was slightly tender. The liver was not palpable, and there was no abdominal tenderness. Laboratory studies showed a bleeding time of 4 minutes (normal, 1 to 3 minutes), a coagulation time (venous) of 14 minutes (normal, 5 to 10 minutes), a positive direct Van den Bergh, and an icteric index of 120. Because of the patient's history, family history and finding of an enlarged spleen, familial hemolytic icterus was suspected, although the direct Van den Bergh and very high degree of icterus pointed toward additional factors being present. A flat plate of the abdomen was reported as showing hepatomegaly and splenomegaly with attention called to multiple radiolucencies present in the gall-bladder area. The patient was admitted on the surgical service at Saginaw General Hospital the following day (October 16, 1947) for further studies and observation. Admission findings were essentially as on the day before. Laboratory work done on October 16 revealed a hemoglobin of 59 per cent, red blood cells 2,950,000, white cells 6,950, with 79 per cent polymorphonuclear cells, 20 per cent lymphocytes, and 1 per cent eosinophiles. On October 17 the urine was reported as cloudy, dark yellow, acid, showing a trace of albumin, negative for acetone and sugar, and containing bile. There were 60 to 65 white blood cells and 12 to 15 red cells per high power field, a few epithelial cells, bacteria, and calcium oxalate crystals. The Kahn test was negative. The icteric index was 57.6 and the prothrombin time 55 per cent of normal. On October 18 the prothrombin time was normal after administration of 1 mg. of synthetic vitamin K; the fragility test showed 83 per cent fragility (percentage of red blood cells hemolized in .5 per cent NaCl, the normal being under 30 per cent). There was beginning hemolysis in .5 per cent NaCl and complete hemolysis at .4 per cent (normal, .42 and .32 per cent). The Van den Bergh was again a prompt direct.

The opinion was that the patient had a familial hemolytic icterus, although the laboratory reports could indicate the possibility of coexisting obstruction of the common bile duct. During this time the patient was symptom-free, receiving a high-carbohydrate, high-protein, low-fat diet and synthetic vitamin K, 1 mg., twice daily. On October 18, bile was again reported in urine. That evening the patient experienced an acute attack of severe epigastric pain radiating through to the interscapular region, with nausea and vomiting, and also experienced a chill. This attack was of about five hours' duration and required morphine sulfate, gr. 1/6, with atropine sulfate, gr. 1/150, for relief after meperidine hydrochloride, 75 mg., had proved ineffective. The patient described this attack as similar to the others but more severe. This was followed by a deepened jaundice, generalized soreness and malaise, anorexia, and tenderness beneath the right costal margin. During this period intravenous fluids and other supportive measures were instituted. On October 20 the hemoglobin was 70 per cent, red blood cells 3,570,000, and white blood cells 23,700 with 89 per cent polymorphonuclear cells. The icterus index was 214.2 and the reticulocyte count 5.7 per cent. On October 21, the prothrombin time was 55 per cent of normal, the coagulation and bleeding times normal, and the stool positive for urobilinogen. It was considered that at this time the picture of obstruction outweighed that of the basic icterus and surgical intervention was indicated. Preoperative preparation included 500 c.c. transfusions on October 21 and 22 without untoward result other than an elevation of temperature to 102°-103° over this period. There was considerable subjective improvement. On October 22, the hemoglobin was 58 per cent, red blood cells 3,200,000, and white cells 9,300. The urine on October 23 was cloudy yellow, acid, showed albumin a faint trace and 10 to 12 white blood cells per high power field. It was thought the correction of the obstruction was of primary consideration at this time because of the apparent obstructive cholangitis present and that splenectomy should be deferred.

The patient was taken to the operating room the afternoon of October 23. Nitrous oxide-oxygen-ether anesthesia was used together with purified extract of curare, 3 c.c., intramuscularly after pentothal sodium induction. A right subcostal incision was made and the viscera visualized. The gastrohepatic ligament was enormously thickened and quite rigid. The gall bladder was enlarged, thickened, and pale. A number of irregular stones of varying size were palpated. The spleen was enormously enlarged and congested. It was freely movable. The sharp edge of the liver was well below the costal margin. It was purplish-brown and there were evidences of fibrous changes on the surface. The common bile duct itself could not be seen, and it appeared that the cystic duct, a very long structure, ran parallel and lateral to it with the junction of the two in close proximity to the duodenum or in its wall. The common hepatic duct was thickened and indurated although only moderately dilated. It was opened and the right and left hepatic ducts sounded and irrigated, which resulted in the removal of a black irregular stone about 1 cm. in its greatest length. Beneath the gastrohepatic ligament there was an inflammatory node which could well have aided in obstruction to the bile flow. Sounds were passed into the duodenum. A T-tube was inserted into the common hepatic duct and a cholecystectomy done. During the procedure 1,000 c.c. of blood were administered. The patient left the table in good condition.

Pathological report: The gall bladder measured 7.5 by 2.5 by 2 cm., with the walls averaging 5 to 6 mm. in thickness and markedly edematous. The mucosa was roughened. There were about 15 small, irregular, friable, black stones, the largest measuring 1 cm. in diameter. Microscopic examination of the wall of the gall bladder revealed an intact mucosa with many mucoid secreting glands beneath it. There were many foci of inflammation. The diagnosis was "acute and chronic cholecystitis and cholelithiasis."

The patient ran a generally good postoperative course, although she was rather listless, and difficulty was encountered in getting her to eat properly. The T-tube functioned well, draining good quality bile. An additional

500 c.c. transfusion was given the day following the operation. The hemoglobin was 82 per cent with 4,210,000 red blood cells and 15,650 white cells on October 25; these values dropped to 70 per cent hemoglobin, 3,950,000 red cells and 14,200 white cells on November 5. The icterus index was reported as 46.1 on October 27, 60 on November 3, and 50 on November 5, with 39 per cent fragility on October 31. On November 3 a light-yellow stool was noted and a manometric determination showed a pressure of 70 mm. (normal, 33) in the duct. The patient was discharged on November 6, after a cholangiogram had demonstrated rapid emptying, with no hepatic dilatation. The tube had been clamped during the preceding few days and allowed to drain only at night without untoward result. Synthetic vitamin K, 1 mg. every eight hours, was administered during the first three postoperative days, together with vitamin supplements and dessicated whole bile capsules thereafter. While it was realized the patient still had her familial hemolytic icterus, she was discharged in a generally improved condition after removal of the obstructive complication. It was planned to give her an opportunity to fully recover from this operation and get in condition for splenectomy.

Follow-up studies with her as an outpatient showed a generally satisfactory course. Her weight increased from 125¼ pounds on November 8 to 137½ on January 21, 1948. She returned to part-time work as librarian on December 5 and resumed full-time work about ten days thereafter. The icteric index appeared stabilized, being reported as 26.6 on November 13, 20 on November 21, 18.7 on December 3, and 21.8 on January 23. The T-tube was removed on November 20 without difficulty or untoward development. The spleen, while still easily palpated on January 21, was thought to be smaller and less tender than before. The blood picture remained relatively constant, although ferrous sulfate and liver extract were administered throughout this period. On November 13, the hemoglobin was 60 per cent, red blood cells 3,140,000, color index .9 per cent, and white cells 5,350, with 73 per cent polymorphonuclear cells. On December 3 the hemoglobin was 62 per cent, red cells 2,710,000, color index 1.1, and white cells 6,850 with 56 per cent polymorphonuclear cells. On January 23, the hemoglobin was 62 per cent, red blood cells 3,330,000, color index .9 and white cells 7,750 with 69 per cent polymorphonuclear cells. The fragility on December 3 was 69 per cent. On January 23, the prothrombin time was 81 per cent of normal and the bleeding time was 3 minutes, 55 seconds. Beginning hemolysis occurred at .5 per cent NaCl and it was complete at .36 per cent, indicating a persistent elevation of fragility. Since the patient was now in a good state of nutrition and appeared well stabilized in regard to her other studies it was decided to have her admitted for splenectomy.

Accordingly, she re-entered Saginaw General Hospital on January 26, 1948. She stated she had no further attacks and felt well in every way, except that she was somewhat easily fatigued and required more rest than formerly. Her appetite was described as good. The sclerae were slightly icteric although the skin presented more the appearance of an even tan than an icterus. She appeared to be in a generally good condition. The chest was clear, the heart negative, the pulse being 72 and the blood pressure 110/70. The cholecystectomy incision was well healed. There was no tenderness over this area or over the spleen, which was easily palpable as a rounded smooth mass extending about 4 cms. below the left costal margin. Laboratory workup showed a cloudy urine of specific gravity 1.026. There was no albumin, a faint trace of sugar, 2 to 3 white blood cells, and a few epithelial cells per high powered field. The hemoglobin was 62 per cent, red cells, 3,540,000 and white blood cells 10,100 with 79 per cent polymorphonuclear cells. The platelet count was 219,480. The Van den Bergh reaction was indirect, 6 mg. per cent (normal, .1-.25). There was beginning hemolysis at .48 per cent NaCl and complete at .44 per cent. Splenectomy was performed on January 27 under nitrous oxide-ether anesthesia with 3 c.c. purified curare extract injected intramuscularly after induction with pentothal sodium. The spleen was roughly the size and shape of a liver. Omentum was adherent to the inferior surface and there were a few adhesions to the parietal peritoneum laterally and superiorly. The great enlargement had the effect of shortening the hilar vessels so that the pancreas was adherent to the spleen. A total of 1,000 c.c. of blood was administered during the operation. The patient left the table in good condition with a pulse of 84, respiration 26 and blood pressure 120/64. Her postoperative course was complicated by the development of a rather profound delayed shock that evening, necessitating the administration of plasma and 500 c.c. of whole blood. She recovered from this episode by the following day and, aside from a subsequent period of nausea and vomiting relieved by gastric lavage, had a satisfactory course except for a superficial wound infection. This was drained on February 5 with subsequent prompt healing.

Pathological report: The spleen weighed 1,295 grams and measured 23 by 12 by 7 cm. On microscopic section the lymphoid follicles were markedly compressed, the great bulk of the spleen being made up of tremendously dilated sinusoids packed with red blood cells. Laboratory studies showed a platelet count of 201,850 on January 28 and 225,070 on February 4. The hemoglobin was 78 per cent, red blood cells 3,990,000, and white blood cells 19,000 with 75 per cent polymorphonuclear cells on February 2, with hemoglobin 78 per cent, red blood cells 2,760,000 and white blood cells 13,800 on February 7. The icteric index was 10 and beginning hemolysis occurred at .46 per cent NaCl with complete at .34 per cent NaCl.

The patient was discharged on February 7 in good condition. She showed evidence of weight loss, but was regaining her strength rapidly. On March 1 she appeared fully recovered and stated that her skin was now clear for the first time she could remember. She had gained eight pounds since her discharge. The icteric index was 6.4 and the hemoglobin 94 per cent, red blood cells 5,010,000, with white blood cells 12,900 and

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Pickrell's Solution in the Management of Skin Excoriations Associated with Enter-abdominal Fistula

By R. A. Stiefel, M.D., and G. T. Kelleher, M.D.
Battle Creek, Michigan

FISTULAS EXTENDING from the small bowel on the skin surface often present a quite perplexing problem as regards care of the skin about the fistulous opening, producing such discomfort as to focus the patient's entire attention upon the small area of excoriation. The difficulty with which this situation is handled is reflected by the long list of remedies which have been suggested for its management. Reported here is a case of entero-abdominal fistula with marked skin digestion which responded well to therapy with Pickrell's solution[1] after failure with several other agents.

Case Report

R. D. B. (Hospital No. 70048) entered Leila Y. Post Montgomery Hospital May 9, 1947, with a diagnosis of acute appendicitis. An appendectomy (R. A. S.) was performed through a Moynihan incision; the appendix had perforated, and local peritonitis was present. Postoperative bowel obstruction prompted insertion of a Harris tube and, on May 29, 1947, reoperation (R. A. S.) through a lower mid-line incision, for release of intraperitoneal adhesions. With the obstruction corrected, attempts to remove the Harris tube were unsuccessful, and it was again necessary to enter the abdomen (R. A. S.), through a left rectus incision, on June 20, 1947, to accomplish its removal. An ileostomy tube was left in place for one week.

At this time, entero-abdominal fistulas opened through the second and third incisions; the opening through the second incision persisted for only a few days. By July 3, 1947, skin pain had become quite marked and repeated doses of opiates were necessary for its control. Local treatments with amphojel paste and zinc preparations and mechanical removal of fistulous drainage were not successful. The patient would not accept the Stryker frame. Copious drainage continued, and the area of skin digestion was about 4 by 4 inches on July 24, 1947.

At this point, the patient was supplied with a bottle of Pickrell's solution (3 per cent sulfadiazine in 8 per cent triethanolamine) and told to apply it with cotton applicators at twenty minute intervals, at the same time keeping the fistulous opening clean. A film developed overnight, with complete relief of pain.

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Applications of the solution several times daily were continued, and even after epithelialization had occurred, a protective film remained which prevented a reappearance of digestion. The fistulous drainage continued to be rather profuse, and at the time of the patient's discharge from the hospital on August 8, 1947, it required several changes of dressings daily. However, by December 1, 1947, the tract had completely closed with no recurrence of skin irritation.

Comment

In this case the skin digestion incident to entero-abdominal fistula was successfully controlled by the use of Pickrell's solution. The protective film provided by it reduced nursing care of the abdominal skin to an occasional change of dressing, as well as affording the patient relief from rather distressing pain. The film also served to protect intact skin against digestive juices.

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ARGYROSIS

(Continued from Page 1230)

diagnosis and treatment. A case was reported of generalized argyrosis following intranasal medication with argyrol for a twenty-year period. Inasmuch as the treatment of this condition is prolonged and painful and does not insure success, it is stressed that prophylaxis is of utmost importance. There has been an increase in this condition since silver salts have once again become popular, through the fact that manufacturers claim that organic preparations of silver do not cause abnormal skin pigmentation. It cannot be emphasized too strongly that large doses of silver salts over a short period of time or repeated small doses for prolonged periods will cause argyrosis, either localized or general.

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Foreign Agricultural Labor Program in Michigan

By Oscar D. Stryker, M.D., and C. B. Hoff
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Oscar D. Stryker, M.D.

UNDER THE laws of the land, and beginning as long ago as almost one hundred fifty years, the government first undertook the health care of part of the population. Since then, Federal medicine has reached an increasing number of persons. No attempt is being made here to trace the evolution of this network into the sprawling thing it is, or to precipitate controversy as to whether it is right or wrong.

The fact is that the sailor, the veteran, some Federal employes, children, veterans' wives and children, and others, are or have been receiving care. The method of providing this care in the longest established programs is through hired professional persons in government institutions wherever possible. Elsewhere, to a greater or lesser degree, private practitioners do render services according to terms of agreement between the agency of government and organized medicine or the individual vendor and government.

In almost all, if not all, of these programs, the government agency through its employes disburses the funds and, in the overwhelming majority of the agencies, sets the conditions under which services may be given and paid for. Some agencies set the fee.

Before the war, along the seaboards, in Florida, and in Texas, the Department of Agriculture maintained government camps for migrant workers. Funds were set aside for both preventive and curative medical services for families housed in or near these camps.

The government used a unique device to supply this care. The Department of Agriculture gave a grant-in-aid to a "private" nonprofit corporation for organizational financing and further grants-in-aid for administering the health services. Members of organized medicine were incorporators of these so-called "agricultural workers health associations" and served on the policy-making boards of directors. As contrasted to the earlier and later patterns of financing and administration of government programs, this setup gave the recipients of medical care and the physician-vendors a voice in policy making of their program, and no official of government was interposed between doctor and patient.

Neither the migrants nor the medical profession in Michigan were affected by this program in the prewar years, because the Midwest had none of these government camps for interstate migrants, even though Missouri had a few government-owned camps for year-around residents, seasonally employed in the cotton fields. As local residents, the indigents among these cotton pickers were eligible for local medical welfare services, so it was unnecessary for government to provide them with health services. However, in other states, including Michigan, the native migrant as a nonresident was not eligible for full medical and public health care. The doctors of Michigan, the hospitals, and the welfare authorities are better able than we are to judge the amount of charity services given the interstate migrants in the prewar years.

With the mobilization of agriculture for war, the War Food Administration undertook a wartime program of recruitment and transportation of agricultural workers. Under this program the Federal government assumed responsibility for the health care of all workers transported by the Federal and, later, the state governmental agencies. The objective here was to relieve the taxpayers of the community from furnishing the health care to workers brought in by government, and at the same time, see that doctors and hospitals were paid. The result was that, for the first time, the taxpayers of Michigan and the professions were guaranteed payment for some interstate migrant care. Yet, under this program, a large number of self-transported workers recruited by growers or self-recruited were not covered.

The Federal government decided to furnish health services to transported workers through the nonprofit corporation device mentioned above. The Medical Society of Michigan, in a 1943 session of the council, delegated B. H. Van Leuven, M.D., as its representative on the policy-making board of directors of the new corporation, which was called the Midwestern Agricultural Workers' Health Association. The board consisted of four delegated doctors and three laymen. Dr. Van Leu-

ven resigned in 1945 and the Council of the Michigan State Medical Society appointed Oscar D. Stryker, M.D., to succeed him.

The corporation was given a grant-in-aid at first, but later a contract was executed between the Federal government and the Association which provided for reimbursement for services rendered. The familiar unit of service system was used.

At the very first meeting of the board of directors, *a policy of using private physicians on a fee-for-service basis was inaugurated. The patient had free choice of available physicians.* The board imposed no fee schedule on profession or hospital, but did request relief rates. Close liaison between medical societies and the Association on professional matters was a policy of the board. *At the beginning of operations, the board stipulated that no alien philosophies or patterns of medicine were to be allowed to creep into the Association.* The announced desire of the board was to conduct the operations in a business-like way, yet supply *good* medicine, not necessarily *cheap* medicine. The board felt that by using local personnel and institutions, migrant labor got the same care through the same physicians on about the same basis as a local resident.

As a general rule, the Association rendered service almost exclusively to foreign workers, West Indians and Mexicans, in thirteen midwestern states. In a few states, by contract between the Association and the state agricultural services, a relatively small number of native migrants transported by the state got similar service from MAWHA. In fact, then, the MAWHA was equipped to give both native and foreign workers health care anywhere in thirteen midwestern states.

During the period of its activity, the association paid over a third of a million dollars to about 4,000 physicians, hospitals, and dentists for care of about 22,000 workers. At this writing, complete financial statistics are not available, but it appears that the cost of the program was about $1.50 per worker per month of his stay in the Midwest during the harvest season. *The cost of administering the care was approximately 10 per cent.*

The MAWHA paid $74,162.86 to 923 private vendors of service in Michigan, for the care of the eligible workers. The number of workers varied from year to year. There were 5,000 in the peak year. For emphasis, it must be repeated that foreign workers were but the proverbial drop-in-the-bucket compared with the total number of interstate and intrastate migrants in Michigan. It can be added that Michigan probably uses more migrant workers per year than any other midwestern state. It can be assumed that Michigan practitioners have a proportionately greater interest in the future health care of the interstate migrant than physicians of other midwestern states.

On December 31, 1947, the government wartime program of labor transportation ended. The foreign labor was shipped back. Native migrants now must find their own transportation and jobs. The by-product of the government program, health aid, has been discontinued. The interstate migrant in Michigan is back where he was before the war as far as health is concerned. In other parts of the country where government camps furnished health services, the interstate migrant lost something he once had.

Because potentially dangerous legislation may be just around the corner, it behooves the medical profession of Michigan, in the interest of the migrants, to study carefully the needs of the workers and determine whether the service they get through a nonprofit corporation such as MAWHA, in the same hospitals through the same doctors with the same choice of doctor, is not the same as we all enjoy.

Referring back to our opening paragraphs, the reader will note that the Association pattern is different than Federal medicine. A corporation of this kind, with doctors and migrants sitting together on the policy-making board, is a workable device, as proven by the MAWHA in five years of operation in thirteen midwestern states. It is attuned to the modern conception of antibureaucracy and return of local functions to local hands.

Curative medical care is the concern of the individual and his doctor, as far as both are able. The migrant public health problems can be worked out by grants-in-aid to state health departments and co-ordination at the national level. But the curative medical care needs of the migrants can best be furnished by an initial grant-in-aid to a nonprofit corporation, composed of migrants and doctors, and by a contract between that corporation and the government. If the government intends to pay the bill for curative service, let the migrants and their doctors work it out without the interposition of "bureaucrats" between them.

Acne Pits

A Supposed Hopeless Disfigurement

By William G. McEvitt, M.D.
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THE INCIDENCE of the chronic skin disease known as acne is very high. So far as the writer knows, no census has been taken, but it is safe to say that it far exceeds other diseases such as syphilis and poliomyelitis. It has failed to attract public attention because it is not communicable and is not attended by the drama and obvious social implications of these other scourges. It is probably true, nevertheless, that disfigurement caused by acne is responsible for more human suffering than both syphilis and poliomyelitis. So many people are afflicted and the stigmata of the disease are stamped on the face to be carried for life. The writer has interviewed many individuals who were in misery because of the condition. Young men and young women fear to enter any social life. They hesitate to apply for employment. Housewives remain prisoners in their homes. Serious psychic breakdown is an imminent danger.

Much of this suffering is unnecessary, as a great deal can be done for these patients. Unfortunately, this knowledge is not widely disseminated, either among the profession or the laity. The problem is that of a disfiguring scar and the techniques of plastic surgery can be applied to minimize the disfigurement. We are speaking now of acne pits, the residuum of the active disease. The writer is not a dermatologist and does not attempt to treat the active disease. Likewise, he does not profess expert knowledge as to the classification of types of acne. The active disease should be treated by a qualified dermatologist. When it is quiescent, and only then, its residual scars can be handled by the plastic surgeon. This is particularly important in the case of those who have had considerable x-ray therapy. It is a vital point, as the destructive effects of excessive radiation on the facial skin are truly appalling. Once the active phase has ended, either by self-limitation or under the influence of treatment, attention can be given to the scars.

The most common scar is, of course, the pit.



Fig. 1. (*left*) Marked acne pitting and scarring with evidence of acute activity. (*right*) Five months after inauguration of program consisting of treatment of acute lesions by a dermatologist followed by two sandpapering operations.

In addition, one sees mounds of scar tissue which are the result of the healing forces reaction to the chronic irritant. Granulation tissue forms in excess and this finally matures into a raised scar. At times pustules coalesce, and when healing occurs, the resultant scar is more in the nature of a crater than a pit. At other times, pustules, burrowing beneath the level of the skin, meet. The result is a sinus which is at all times subject to reinfection.

The surgical treatment of these scars is as variable as the lesions themselves. In the not too distant past, the only method used was dekeratinization with some caustic such as trichloracetic acid. This is still a valuable procedure in some cases. It received disrepute in the past, as it was sometimes used by charlatans. In the writer's program, abrasion by means of sandpaper is the sheet anchor. This is carried to the point of profuse capillary bleeding, after which a grease gauze dressing is applied and left in place for seven to ten days. When the dressing is removed, the area is found to have epithelialized. Large pits and sinuses are excised and mounds pared as a preliminary procedure. The anesthesia is local, usually with 1 per cent procaine HCl. Certain deep pits, often discolored and in situations poorly accessible to abrasion, are sometimes treated with 25 per cent trichloracetic acid, but this must be used cautiously.

The typical case is first interviewed and the possibilities and impossibilities explained. If any

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activity is present, an operation is deferred until the activity has been controlled by the dermatologist. A plan of correction is then mapped out. Large sinuses, mounds, or pits are treated first, and



Fig. 2. (*left*) Diffuse pitting caused by acne. (*right*) Result of two sandpapering procedures and slight application of 25 per cent acetic acid.

then abrasion is begun. This is continued from one affected area to the next until all are treated. Second, and sometimes third, operations are required over a given area. In these multi-stage cases, two to three months are allowed to elapse between operations on the same area. Extremely recalcitrant cases may require even more stages, but this is unusual.

No case has been found to be hopeless; some definite measure of improvement has always been gained. While a small number of cases show such dramatic results that the former sites of the lesions are difficult to find, it would be unfair to offer this as a general promise. The patient must understand from the first that while perfection is usually not possible, great improvement can be realized. It is the writer's hope that knowledge of these aids in overcoming post-acne scarring will be disseminated more rapidly for the benefit of those afflicted.

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DOGS MAY BE POISONED BY CHEWING ON PAINT

Don't let the pup chew on anything painted, warns the American Veterinary Medical Association. Ordinary paints often contain lead, and there are cases on record of dogs developing lead poisoning after chewing wooden objects covered with such paint. In one case, the animal was poisoned by paint that had been used on his own house.—*Science News Letter,* October 23, 1948.

Paget's Disease in Three Male Siblings

Clinical Report

By Louis A. Schwartz, M.D.

Detroit, Michigan

PAGET'S DISEASE, or osteitis deformans, was described first by Sir James Paget in 1877. It is a chronic affection of the bones, characterized by enlargement of the head, dorso-cervical kyphosis, enlargement of the clavicles, spreading of the base of the thorax, and an outward and forward bowing of the legs. There is some evidence to show "that this condition is due to a perversion of some internal secretion." The skull, spine, and long bones are chiefly affected. The process is a rarefying osteitis which gradually involves the center of the bones. There is also new bone formation, both subperiosteal and myelogenous. The disease, as a rule, begins in the sixth decade, accompanied with indefinite pains. Often the individual grows shorter when the legs become more and more bowed.

Recently, Moehlig and Abbott[1-4] have reported two cases of Paget's disease in which they reemphasize the close relationship between calcium and carbohydrate metabolism that had been observed clinically by them involving an osteolytic or osteogenic process. Three brothers who developed Paget's disease will be reported here. However, there was no history of diabetes or calcium disturbance in the family. Family history was otherwise negative.

Case Reports

Case 1.—Mr. J. S., single, was referred for psychiatric treatment due to a long record of overt homosexuality. He was born July 31, 1902, in a small town in Pennsylvania. As a child he suffered from the usual childhood illnesses, except mumps and whooping cough, without complications. At the age of fifteen, he suffered from pneumonia and was hospitalized for two weeks. At the age of eighteen, he suffered from "gnawing pains" in the abdomen. He frequently developed nausea, and had frequent attacks of epigastric distress once every six months for about six years. He also developed a feeling of fullness in his throat and chest, particularly at night. For years he awakened about three hours after retiring

with a choking sensation and a feeling that he had to dislodge something from his throat and chest. He would get relief by vomiting, and reported that he would bring up a large bolus or mass which was so heavy "that when it left my mouth and dropped into the water in the toilet, it caused the water to splash on the floor." He always was underweight and complained of eructations. He used alcohol to excess "in order to get my mind off my stomach."

In 1925 he had his first gastrointestinal series, but no ulcer was reported. A year later he was examined at the University Hospital, Ann Arbor, Michigan, and was told he had no organic disease but that he was "high-strung" and that his trouble was due to "nerves," and that he should "take it easy." He admitted that from early childhood he had participated in homosexual activities. From the age of eighteen he had had frequent homosexual experiences as a passive partner, usually performing acts of sodomy. His first heterosexual experience occurred at eighteen, at which time he contracted gonorrhea. He had no other experience for many years, as heterosexual contacts were distasteful. In 1944 he was examined at the Jennings Hospital in Detroit and was found to have a peptic ulcer. Under dietary treatment he made a good recovery for about a year, and then had a recurrence of his ulcer. He was advised to have his tonsils removed, but he refused. He was circumcised in 1926, and had his tonsils removed in 1930. Physical examination revealed a younger-appearing man than forty-five years of age. He presented a paradoxical youthful appearance, due to his clear skin and youthful manner. He was 5 feet 6½ inches tall, and weighed 106 pounds. He found it necessary to shave every other day. He complained of pain in the shaft of his legs, especially on the left. Fasting blood sugar was 70.2 mg. and urinalysis was negative.

Ralph A. Johnson, M.D., reported as follows:

"This patient was admitted to the Charles Godwin Jennings Hospital, September 1, 1944, and discharged September 6, 1944. His complaint on admission was of gastric pain. He states that he was hospitalized five years ago because of an ulcer. He was treated at that time by diet and alkalies, and his symptoms disappeared. He has been quite well since that time. His present attack began about one week ago. There is a relationship with the food ingestion, the pain coming on about two hours after eating. The pain is promptly relieved by alkalies. There has been no vomiting or tarry stools. Past history includes an appendectomy five years ago. He had the usual diseases of childhood; otherwise, the inventory by systems is negative. He states that he has two brothers who have had gastric ulcers. Physical examination reveals a well-developed white male, appearing his stated age of forty-two, and not appearing acutely ill. The pupils are equal and regular and react to light and accommodation. The ears, nose and mouth appear to be normal. The neck reveals no adenopathy, and the thyroid gland is not palpable. The chest is symmetrical with good bilateral expansion. Auscultation and percussion of the chest are normal. The heart is not enlarged. The apical impulse is clearly felt within the mid-clavicular line. The rate is 80. The rhythm is regular. Heart tones are clear and distinct. There are no murmurs. Blood pressure is 112/60. The abdomen reveals some epigastric tenderness to palpation, with voluntary muscular rigidity. No masses are palpable. The extremities are normal. As to development and musculature the reflexes are physiological. The genitalia are normal male, without herniation. Gastrointestinal x-rays studies were made. Conclusions: There is marked deformity of the duodenal bulb due to scarring from a chronic duodenal ulcer, but the actual ulcer crater was not shown at this time, and there was no significant tenderness to suggest a reactivation. The motility of the barium meal through a four-hour period is considered to be approximately normal, although there is a very slight residue of barium remaining in the stomach at this time. The soft tissue shadows of the abdomen are shown in a flat plate study and appear normal. Routine laboratory reports are within normal limits. The patient was placed on routine ulcer therapy and has made satisfactory progress."

On February 26, 1947, a report by Dr. E. W. Hall of x-ray films taken because of dull continuous pain in the patient's legs, was as follows: "The examination of the left leg in anteroposterior and lateral projections shows increase in caliber of the shaft of the tibia with thickening of the cortex and irregular bowing characteristic of osteitis deformans of Paget's type. The ankle joint has a normal appearance, and there is no evidence of osteomyelitis or traumatic lesion. The examination of skull included stereoscopic lateral views as well as films in anteroposterior and posteroanterior projections. There is no evidence of fracture of the tables of the skull and there is no proliferative or destructive lesion. There are no findings of intracranial disease. The sella turcica is normal. There is no abnormal calcium deposit. Conclusions: The examination of the left leg shows changes quite characteristic of osteitis deformans of Paget's type, there being thickening of the cortex, bowing and irregular trabeculation. The study of the skull shows no evidence of Paget's disease involving the skull and no intracranial disease."

After the diagnosis of Paget's disease was made, the patient reported that an older brother had had a similar condition, which was reported by Dr. Grosvenor W. Bissell of Buffalo, New York, on August 21, 1947, as follows:

Case 2.—Mr. B. S., is a fifty-five-year-old married, white male. He first discovered that he had Paget's disease of the pelvis when he had an x-ray examination for a renal stone nine years ago. He presented no complaints until three years prior to admission to the hospital, when he tried to mount a horse and found he could not. He has noticed bowing of the right leg since that time. Six months previous to my examination, he had increased difficulty in walking, and his hearing began to diminish. Three weeks previous to my examination, he had given up his work and the driving of his car. His head size had

not changed. The rest of his physical inquiry was negative except for the fact that he had had a cough productive of a small amount of sputum for six to seven years; that he had had a nasal polyp removed at the Veterans Hospital, four years previously. Six years previous to examination, he had had a coffee-ground emesis, and a proven ulcer of the duodenum was demonstrated on x-ray. The rest of his history was not remarkable, save that he has had measles, chicken pox, typhoid, malaria and a so-called renal abscess associated with his stone nine years previous to examination.

Physical examination on November 7, 1946, showed a man with a large head and prominence of the right side of his face. The legs were markedly bowed outward. He was limping and walked with a cane, favoring his left leg. Pupils were round, regular and reacted to light. Both ears showed an enormous amount of dry wax, and removal of the wax from the ear in which he was complaining of deafness resulted in a remarkable increase in his auditory acuity. The trachea was central. There were some moist and sticky rales in both bases. The lungs were, in general, hyper-resonant, and there was some suggestion of emphysema of the chest. The heart was not enlarged; the rate was 80 and was regular; blood pressure was 120/80. The abdomen showed the left lobe of the liver to be palpable to a slight degree in the epigastrium. The left kidney was just palpable. Extremities demonstrated bowed femurs, and there was a marked atrophy of the muscles of the left lower leg. The forearms were heavy in development and also showed some evidence of muscular weakening. He had some pigmentation over the glans penis, and the left testicle was slightly atrophic. Prostate was slightly enlarged but was not stony hard.

Neurological examination demonstrated slight diminution of the knee jerks and ankle jerks bilaterally with a bilateral foot drop. There was marked weakness of the lower left leg with a good amount of muscular fibrillation and atrophy of the muscles. Sensation was intact. There was no saddle anesthesia. Vibration sense was intact, and position sense intact. The atrophy of the leg was startling, extending up to the thigh. There was weakness of the entire left lower leg on flexion and plantar extension of the foot. There was bowing of the femurs in the outward direction. There was no loss of hand strength, and there was no remarkable evidence of loss of power in his upper extremities. *Laboratory Findings:* Blood count and differential count were normal. Urinalysis was not remarkably abnormal. Sedimentation rate, corrected, was 25 and 26 millimeters. Wassermann test was negative. Sugar was 79 mg. per 100 c.c. Calcium was 11.3 and 4.8. Acid phosphatase was 5.4. Alkaline phosphatase was 23.5 and 31.9 on two occasions.

Examination of the skeletal system showed the following positive findings: There was evidence in the skull of a marked degree of Paget's disease, the entire skull being thickened with many islands of sclerotic densities as well as many areas of reduced densities. The appearance was characteristic of Paget's disease. Cervical spine showed some narrowing of the body of the sixth cervical vertebra. The dorsal spine showed marked Paget's disease involving the vertebrae particularly in the upper two-thirds of the dorsal spine. There was marked rarefaction of the seventh, eighth and ninth dorsal vertebrae. The seventh vertebra was narrowed to about one-third its normal width. The body of the eighth was not visible in the lateral view. The lumbar spine showed a marked degree of Paget's disease. The bodies of the vertebrae had maintained a normal contour. The pelvis and hip showed marked evidence of Paget's disease with softening of the bone; little actual deformity was demonstrable. The femurs showed a marked degree of Paget's disease with some thickening and considerable osteoporosis. There was little deformity. The lower legs showed no characteristic changes. The shoulders and humeri showed Paget's disease bilaterally. There was calcification of the subacromial bursa on both sides. The forearm showed bowing of the ulna in both arms, with definite Paget's disease demonstrable in the ulna on both sides. The radii appeared normal. The lungs were clear. The heart was slightly enlarged. The transverse diameter of the chest was 26.6 cm.; the heart, 15 cm.; the aorta, 5.5 cm., and there was definite calcification of the arch of the aorta. There was Paget's disease demonstrable in most of the ribs, with definite expansion of the proximal end of the seventh rib on the right.

Mr. B. S. was seen on January 11, 1947, at the Johns Hopkins Hospital by Dr. John E. Howard, and the conclusions that Dr. Howard drew at that time were similar to my own. This was unquestionably a case of classical Paget's disease, but the neurological findings as I have described could not be credited to the Paget's disease *per se;* he probably was also suffering from a neuromuscular disease of some type. The following is part of the letter written by Dr. Howard, in which this opinion is given: "The last and most interesting feature was a neurological one. He had patchy evidences of muscular atrophy; quite a marked foot drop on the left, moderate on the right; very weak psoas muscles, and atrophy of all the muscles of the legs, although not uniformly so. The reflexes were normal and there were no sensory changes. It seems inconceivable that the lesion could be due in any way to pressure on the cord, and we were inclined to believe that it had nothing to do whatever with the Paget's disease. There seems, unquestionably, anterior horn cell degenerative changes, as quite a few fistulations were visible at times. Whether this is amyotrophic lateral sclerosis or an atypical form of progressive muscular atrophy, I do not know."

The chemistry studies and other work-ups done at the Johns Hopkins Hospital were essentially the same as those which we did in my own laboratory. Mr. B. S. at the present time is being followed by myself and Dr. Charles Voltz, who reports that there is no improvement in his condition; in fact, he seems to be running a progressive downhill course as one might expect if the diagnosis of an essential muscular dystrophy or atrophy or anterior horn cell lesion is justifiable, and I believe it is. He is being treated at the present time with vitamin E and also with testosterone; both therapies are entirely unsatisfactory.

Another brother, the eldest sibling, Mr. T. S., aged fifty-seven, also suffered from Paget's disease. He had been hospitalized in a U. S. Navel Hospital in Pennsylvania in 1940. A description of his case is as follows:

Case 3.—This fifty-seven-year-old male who received a disability pension was first seen by me on November 3, 1944. He complained of difficulty with close work and "hemorrhage" in the right eye. Vision in right eye cycloplegic with correction: 1/60; unimproved with pinhole glasses. Vision in left eye with correction: 6/15-2, Reads Jaeger 5. External examination by means of a Loupe and Corneal microscope is essentially negative. Ophthalmoscopic examination reveals multiple retinal hemorrhages; both eyes with condition, most likely hypertensive retinosis. Must rule out luetic infection as well as diabetes. X-ray report: The cranium and the mandible show pronounced evidence of osteitis deformans. There is no evidence of disease of the lungs. The heart is considerably enlarged to the left. The bones of the shoulder girdle and the ribs also show marked change, due to osteitis deformans. Impression: Osteitis deformans or Paget's disease, arteriosclerosis. Cardiac classification. The negative serology and the normal range blood sugar tend to rule out lues or diabetes mellitus. Blood serology, negative. Blood sugar, 90 mg.; nonprotein nitrogen, 33.5 mg.

Report of physical examination on November 6, 1944: Origin and date of incurrence of disability as alleged by claimant: pains in the legs and hips for past fifteen years. Last VA: November 15, 1938, at Naval Hospital, Philadelphia. Occupation: Unemployed for the past three years. Treatments: None. Illnesses: None. Hospitalization: Bronx, N. Y., in 1937 for one month for leg. Operations and injuries: None. Habits: Does not smoke, drinks coffee and beer seldom. Present complaint (subjective symptoms, not diagnosis): Aching in the bones generally, especially in the hips and legs. Early fatigue. Shortwindedness. Gaseous indigestion. General appearance: nutrition, good; muscular development, fair; carriage, poor; posture, very poor; gait, waddling. External structures, each eye—normal; internal structures, each eye—not practicable. Ears: Ordinary conversation heard: right, 20/20 feet; left, 20/20 feet. All sounds and murmurs exaggerated by change of position.

Cardiovascular system: Heart sounds: Loud blowing systolic murmur heard all over precordium, loudest at apex and transmitted to the left axilla. Second sound is likewise distorted and mushy. Pulse is 88 reclining, 92 seated and 96 standing. No exercise done because of painful legs and early fatigue. Very slight visible pulsation in base of the neck. Systolic murmur transmitted out subclavian and carotids. Moderate venous distention about head, neck and upper trunk. Sclerosis of peripheral vessels moderately advanced. Heart is enlarged to the left. There is definite pitting edema of both legs. The liver margin is felt two fingers below the costal edge on deep inspiration but no definite enlargement is made out. No moisture is found in the chest. No dyspnea or cyanosis.

Rheumatism: articular. Right hip affected. There is no swelling, crepitus, atrophy, ankylosis, or limitation of motion. Patient, however, complains of pain in both knees, ankles, and right hip. The normal planes of the joints are altered due to bowing of the legs of fifteen years' duration. This bowing is quite obvious at this time. Diagnosis: Osteitis deformans (Paget's Disease). Urinalysis: Amber, acid, specific gravity Q.N.S. Albumen, 4-plus (50 mg). Negative sugar. No casts noted. Few shreds of mucus; 2 to 4 leukocytes and 4 to 6 erythrocytes per high dry field. Rare squamous epithelium cells. Blood: 5,350,000 red cells; 8,200 white cells; hemoglobin 14.5 gm. Band cells, 2; segmented cells, 68; lymphocytes, 26; basophiles, 2; monocytes, 2.

(1) Chronic heart disease. (a) Arteriosclerosis, general moderate; arteriosclerosis of the aorta. (b) Mitral insufficiency; enlargement of the left ventricle; sinus tachycardia. (2) Osteitis deformans (Paget's disease). (3) Albuminuria, four plus. (4) Sinusitis, maxillary, bilateral. (5) Neuroretinitis. (6) Presbyopia. (7) O.D. myopia. O.S. myopic astimatism. Ear, nose and throat examination: Septum: perforated, crusted. Middle Meatus R.: purulant discharge. Inferior Turbinates: R. normal; L. polypoid degenration. Sinuses: Maxillary sinuses do not transilluminate. Diagnosis: Sinusitis, maxillary, bilateral. Eye Examination: Vision O.D. 20/200; Manifest: O.S. 20/40. Cycloplegic O.D. .50 Sph. Corrected O.S. .75 Sph. —.50x140 degrees. Retina: bilateral neuroretinitis. Diagnosis: (1) Neuroretinitis. (2) Presbyopia. (3) O.D. myopia; O.S. myopic astigmatism.

Chest examination: Examination of the chest shows an asymmetrical thorax, smooth diaphragm and clear costophrenic angles. The liner markings throughout both lung fields are accentuated. There is no definite evidence of active pulmonary tuberculosis. Numerous ribs, the left clavicle and the upper ends of the humeri show rather marked evidence of Paget's disease. The aorta is not enlarged but shows evidence of arteriosclerosis. The transverse diameter of the heart is slightly increased and is confined primarily to the left ventricle. X-ray examination of skull, pelvis, both tibiae and both femurs show changes characteristic of Paget's disease. It is interesting to note that this individual, who was unmarried, had also been an overt homosexual all his life but had received no psychiatric treatment.

Summary

1. A clinical study has been reported describing the condition of Paget's disease in three brothers, ages fifty-seven, fifty-five and forty-six.

2. The eldest brother, in addition, suffered from a neurological condition, either amyotrophic lateral sclerosis or an atypical form of muscular atrophy. The two younger brothers had demonstrable duodenal ulcers and were overt homosexuals from adolescence.

(Continued on Page 1302)

Detroit Physiological Society

Session of May 27, 1948

Eating the Ogre. (Address of the Retiring President.)

Conrad R. Lam, Department of Surgery, Henry Ford Hospital, Detroit.

A children's fairy tale relates how a certain ogre was liquidated by a cat named Puss-in-Boots. A psychological approach was used to persuade the ogre to exercise his own magic power to change himself into a mouse, after which he was quickly swallowed. Leaving the field of folklore and coming to modern medical literature, we find accounts of another ogre whose presence, or the fear of whose presence plagues the doctor. This is the ogre of "shock."

Different adjectives have been placed before the word "shock" to qualify it. Thus, we have traumatic shock, operative shock, postoperative shock, burn shock, obstetric shock, medical shock, primary shock, secondary shock, vasogenic shock, experimental shock and even chronic shock. The theories as to the cause of shock fall into four groups: (1) the nervous exhaustion theory of Crile and others; (2) the traumatic toxemia theory; (3) the theory of exhaustion of the adrenal medulla, and (4) the theory of blood volume deficiency. Increasing clinical and experimental evidence has shown rather conclusively that the first three of these theories are not tenable. Large operations which stimulate many nerves are carried out and if blood replacement is adequate, there is no fall in blood pressure or "shock." The theory of traumatic toxemia has been easily disproved. If the venous return from a traumatized limb is blocked, the syndrome occurs just as readily. The injection of extracts of injured muscle is not lethal.

It has been frequently stated that "burn shock" is responsible for many preventable early deaths from burns and it has been urged that plasma therapy precede local treatment in such cases. Although it is true that there is some loss of plasma from the burn to the exterior and into the neighboring tissues, experience has shown that there is plenty of time to apply local dressings to relieve pain and minimize infection before it becomes necessary to attend to blood volume replacement. There is evidence at hand to suggest that whole blood is better than plasma for this replacement.

By the process of elimination, the ogre of shock has been reduced to mouse-like proportions. Traumatic shock and operative shock are identical with hemorrhage, which is easily treated. Obstetric shock falls into the same category. Experimental shock is likely to produce something which has no counterpart in actual experience. So-called medical shock had better be called something else. It is suggested that what is left of the ogre be eaten, that is, that we abandon the use of the word in medical terminology. Experience has shown that it is practical to go through clinical histories or surgical writings and edit out the offending word, substituting words more descriptive of the actual conditions. The word "exsanguinated" can usually be used instead of "in shock."

In Memoriam



F. E. McAllister

FRANK E. McALLISTER, Treasurer and Trustee of the Michigan Medical Service, died of coronary thrombosis on the train, coming out of Chicago, on his way home from the meeting of the Blue Cross and Blue Shield Commissions at French Lick, Indiana. Mr. McAllister had served three years on the Board of the MMS, attending all conferences and meetings, including the Los Angeles meeting in March and April, giving of his rich knowledge and advice in finances. He was enthusiastic for Michigan Medical Service and extremely interested in the social problems of medicine. He was a Director of the Grand Trunk Western Railroad, had been mayor of Kalamazoo, and was Director in eight or more prominent industries in Kalamazoo, Battle Creek, and Portland, Maine, as a retired businessman. He was also president of the Home Savings Bank, National Railway Appliance Manufacturers Association of America, and of several other railway organizations.

In the People's Interest

Approximately three hundred doctors have been appointed to the various regular committees of the Michigan State Medical Society; an additional one hundred to the special committees of The Council. Four hundred doctors, nearly one-tenth of our entire membership, are all delegated to specific tasks of investigation, study, and recommendations relative to some phase of the many problems facing Michigan Medicine.

Committee work is highly important and members should feel that by their participation they are contributing something toward increasing the prestige of their profession. Were it not for the deliberations of these committee members, the work of The Council and the officers of the Michigan State Medical Society would be enormously increased. There would not be hours enough in each day, nor enough days in a week, to complete our business.

It is a curious fact that the principal functions of the majority of our committees consist of considerations whose solutions are all in the interest of the health of the people of our state. There is little or no self-interest in the operations of the Michigan State Medical Society.

E. P. Sladek, M.D.

President, Michigan State Medical Society

President's



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Editorial

TUBERCULOSIS AND THE CHRISTMAS SEALS

THE FRONT pages of this number of THE JOURNAL feature the Christmas Seal and the program for the finding and treatment of tuberculosis. Mention of this subject occurs frequently in the contacts we make every day, but we can credit to the medical profession the fact that tuberculosis, which used to be the great killer, is now relegated to the lower ranks. Diagnosis and recognition of the disease early has contributed to the most favorable position of our public health condition in regard to tuberculosis. The committee of the Michigan State Medical Society is a working committee, and has helped materially in our great advance; on another page we are publishing a very late report of the Committee on Chemotherapy and Antibiotics of the American College of Chest Surgeons, adopted September 23, 1948, on "The Use of Streptomycin." This report substantiates some notes we have published on the use of streptomycin, and is timely; hence, its inclusion in this number of THE JOURNAL.

THE EWING REPORT

MANY COMMENTS have been made about the Ewing report. We have published abstracts and comments, and the Secretary of the American Medical Association has devoted several of his weekly letters to the subject. None of us likes the portent of this report, the President's advocacy of compulsory medical service, or the ten-year program of alleged health service, but we must all give heed to the conditions which made this report possible and plausible. There is a challenge to the medical profession in the whole socializing change that is spreading over the country. We have accepted many of these social changes and have fostered some of them, but we have failed to meet the increasing needs of the world today. Laboring people are demanding greater health security, and John L. Lewis, on October 6, 1948, announced the provision of complete medical and hospital services to his workers and their families. The announced program of CIO is to give increasing amounts of health service to its members, which will be the basis of most of the labor demands in 1949.

What has the medical profession done to meet this trend, to supply the services that are being demanded and are even being offered in places? The Michigan State Medical Society and numerous other state medical societies have attempted to provide for this need. Michigan Medical Service first gave complete medical and surgical care—home, office and hospital, to those of our subscribers who chose the whole coverage contract. The rates were not adequate, and people would not pay enough to make them adequate, but the surgical plans have worked exceedingly well. We should now offer a complete contract to groups willing to pay for it, and develop an experience in small groups. The Michigan Medical Service contract is now being liberalized, and this added service might well be listed. That would give response to those who claim the voluntary plans cannot hope to solve the health problem as it is developing.

MILITARY SERVICE FOR DOCTORS

WHEN THE present draft law was ready to be passed, it provided for the drafting of doctors up to the age of forty-five. Active opposition eliminated this section just before the bill passed, but the Armed forces began calling for extra doctors. With the new draft the military forces have estimated that 4,000 doctors will be needed. Several radio broadcasts have called attention to this need for doctors in the services. *The Journal of the American Medical Association* had an editorial on the subject, and it has been mentioned by several medical journals and other publications, including the public press.

A proposal has been made to call back into the service all doctors who were trained under ASTP and V-12, or such of them as are capable of military duty, on the theory that the Government paid for part or most of their professional training, and while they technically served in the Army or Navy, they actually saw no service and could be considered as still owing a debt of repayment to the Government. It was thought this group of doctors under twenty-six would provide sufficient medical

officers for most of the needs of the service. As always, the administrative groups and higher ranks would have to come from older and more experienced men. The Army and the Navy are again asking for help in recruiting needed doctors. The draft law provides that men cannot be taken into the military ranks until provision has been made for their proper health service. Until an approximate 4,000 doctors can be added to the rosters of the three forces, that cannot be guaranteed.

In passing, let us make a suggestion for the forming of a medical department in the military services that would work. We made this suggestion in December, 1942, and repeated it in detail in August, 1943.* The maintenance of our military forces requires medical officers, and at times many of them. It is well known what proportion is needed. We would suggest that the number who will be needed in active military service be determined, and these men selected, commissioned, and given an orientation course so they will know something about the paper work, the special military therapeutic procedures, and how to wear their uniforms. They could then be sent home to continue their private practices. When an emergency developes and more than a skeleton crew of medical men is required in any part of the world, they can be called and flown to their destination within thirty-six hours, practically any place in the world. Again this suggestion will not be followed for one reason at least—it would be efficient, but would require a large degree of administrative ability.

We are passing this information along to our members, urging that those who would like a term of military service or a complete military career—get in touch with the proper officials, the Surgeons General of the Army, Navy or Air Corps. A sufficient number of applicants would stop the necessity of compulsory enlistment. Whatever amendments are made to the draft bill, they will probably not be an authorization of the drafting of doctors of medicine but will authorize the drafting of persons with special talents and training. That would include us.

*But would it not have been feasible to have commissioned our doctors of medicine, returned them to their private practice until two or three months before they would be needed, then have called them in for intensive training and sent them to duty? This would have taken a good amount of thought at the top, but could have been attempted, at least, and would have tapered off the civilian practice to the necessary changes gradually. Can this be done in the next war, or will we have to make the same mistakes and learn all over again?—Editorial, JMSMS, August, 1943, Pg. 624.

GREATEST ATTENDANCE

THE ANNUAL SESSIONS of the Michigan State Medical Society are becoming great institutions of medical progress. The programs for many years have been outstanding, but the one for 1948 was practically a national medical meeting, and the attendance indicated the intense interest which has been aroused by the Michigan type of meeting. Our total membership is 4,749, and 2,751 M.D.s registered at the meeting in Detroit. That's 58 per cent, an amazingly high response. Guests and visitors made up the balance of 3,399.

The Program Committee and the executive officers of the Michigan State Medical Society are deserving of the greatest praise for their efforts. Many members, both at the meeting and since, have commented on the excellence of the program and the large attendance.

The Grand Ballroom at the Book-Cadillac was crowded for the scientific meetings. Every seat was taken on the main floor, and the balconies were crowded. Hundreds were standing in the aisles, and crowds at both entrance doors were unable to get into the mammoth room. We have attended many meetings of the Michigan State Medical Society and other medical organizations, and we have never seen a more enthusiastic or more impressive session.

We take this opportunity, on behalf of the Society, to thank the guest essayists and the exhibitors who, by their scientific contributions and willingness, made this meeting possible.

TRUE OR FALSE

THE TIMING is so exact that we cannot but wonder whether the article in the October, 1948, *Woman's Home Companion* by J. D. Ratcliff, "Give Young Doctors a Break," is just another evidence of the use of taxpayers' money for Police State Propaganda. Oscar Ewing, Federal Security Administrator, has just released his report to the President and his plan for a ten-year program of health care and training 22,000 new doctors of medicine in eleven years.

Ratcliff tells of an exquisitely trained young surgeon who "knew he would be barred from practice in hundreds of communities by men with a fraction of his skill." The article outlines, at length, "Dr. Jim's" training, his difficulty in securing ap-

pointments as intern, junior assistant resident, assistant resident, and resident. "In the United States there are probably not more than 125 senior residencies in surgery," says the article, and "the hundreds of Jim's among the five thousand odd physicians who will enter practice this year will face the same barriers," and so on. There are only 125 opportunities, but there are "hundreds" with this training. The article itself contains the evidence of falsity.

"There are many towns of fifty thousand people with not a single modernly trained surgeon"—where did he look? or was he too nearsighted? There is probably not a city of that size in the United States without several members of the American College of Surgeons—and this aggregation checks its Fellows rather thoroughly for modern training.

The inference of the whole article is that young doctors, well trained by our modern schools, cannot get hospital privileges, especially in small towns. Our experiences are just the opposite.

Ponder this: "In other situations young physicians receive hospital apopintments, but have no patients referred to them by older doctors. This happened to a young surgeon in a Pennsylvania town. Other physicians were quick to detect his remarkable skill. In his first year he performed only eight operations. Each patient was the wife of a physician." How come? How could the physicians "detect his remarkable skill" if he had no cases but the wives who were all sent to him because of this remarkable skill? Bosh!

But to return to "Jim"—"he knew he would be barred from practice." Furthermore, "he knew that he would not have access to the hospital libraries with the books and journals which he could not afford. Nor would he have the elaborate equipment and diagnostic aids which he had been taught to rely on"—so he accepted a job as instructor in surgery in his own Medical College for $3,600 a year.

Where has this author gone for his research in writing this article? Has he seen any of our hospitals in Michigan, cities of 40,000 for instance? They have good libraries and journals, and their diagnostic equipment is probably less elaborate, but just as efficient. Good diagnoses are being made every day. About the job of $3,600 per year, we have several friends who have tried to get well-trained assistants and were asked to pay them $12,000 to $18,000 for young men. just completing their Specialty Board training and never yet in practice. Have these young men gone hog wild as their Board Instructors seem to have done?

The earnings of the profession do not warrant such demands. A salary of $3,600 as a starter is not high pay, but is not far from what the doctors of several years' experience probably get, net—for that represents about $6,000 gross receipts.

This article was written definitely for propaganda, because a full-page advertisement appeared in the Chicago *Tribune,* September 21, 1948, offering reprints: "Public opinions brought to bear by civic-minded individuals and organizations can help to remedy this *deplorable* situation. This is a part of the *Companion's* Program for Public Service." How many of our tax millions are being syphoned by the Washington Bureaucrats into this type of publicity? Oscar Ewing has consolidated the propaganda offices into his own organization, and his arguments are to the effect that the health situation of the nation is deplorable—an anacronism with a life expectancy which has been increased over twenty years in this generation. There must be something right to accomplish such results.

And with such propaganda in our "Slicks" which used to be honest, respectable magazines, "There's something ROTTEN in America (not Denmark)."

MERCY HOSPITALS' BLUE CROSS PARTICIPATION

SISTER MARY REGINA, superintendent of Mercy Hospital in Muskegon, has signed the Inter-Hospital Agency Contract for participation with Michigan Hospital Service, effective October 7, 1948.

Sister Nicholas, superintendent of the Leila Y. Post Hospital in Battle Creek, telephoned to the Detroit office October 8, 1948, asking for a contract for participation, and thus became effective October 19. Several other Mercy Hospitals are reported to have made similar requests. The doctors in Michigan will be extremely pleased with this break in the long-continued non-participation of the Michigan Mercy Hospitals. At least one of these hospitals has been accepting Blue Cross patients and absorbing the difference between what Blue Cross pays non-participating hospitals and the actual cost, believing that to be a good public relation activity.

The trend now evident seems to mean that the Mercy Hospitals will soon be in participation again with the Blue Cross movement, with which they had so much to do in developing. Heretofore they participated as a group of fifteen hospitals, but now each hospital will make its own contracts, which will be a much more flexible relationship. The patients of the state will welcome this move with open arms, as it will allow a great many of them to go to the hospital of their real choice, and still receive the benefits of their Blue Cross membership.

PRESIDENT-ELECT



WM. E. BARSTOW, M.D., of St. Louis, Michigan, was elected this year by the House of Delegates as President-Elect of the Michigan State Medical Society. He has been very prominent in medical and civic affairs over many years.

Dr. Barstow was born September 15, 1877. He graduated from the Ithaca High School in 1896 and the Michigan University Medical School in 1905. He has practiced in St. Louis since that time.

Dr. Barstow is a life member of the Masonic Lodge, was president of the St. Louis School Board for six years, served on the Draft Appeal Board during the Second World War for four years, has been president of the Rotary Club and wears a ten-year pin for perfect attendance. He has served five years on the St. Mary's Hospital staff in Saginaw and is now Chief of Staff of the R. B. Smith Memorial Hospital at Alma. He has been very much interested in Scouting and has received the Silver Beaver for long service. He is now on the Executive Committee of the Saginaw Area Council of Boy Scouts of America. He has served for twelve years on the Council of the Michigan State Medical Society, the past year being Vice-Chairman. He also served two terms as Secretary and two terms as President of the Gratiot-Isabella-Clara County Medical Society, and has served for years in the House of Delegates of the MSMS several times.

This represents an active life of public interest and foretells a busy two years of service to the Michigan State Medical Society as President-Elect and President.

Dr. Barstow's friends and admirers congratulate him on the greatest honor the State Medical Society can render to him.

NEW COUNCILORS



WILLIAM BROMME, M.D., of Detroit, Editor of the *Detroit Medical News,* was elected as one of the new Councilors for Wayne County by the House of Delegates at the meeting on September 21, 1948.

Dr. Bromme was born on May 3, 1900, at Louisville, Kentucky. He graduated from the University of Michigan in 1931. He located in Detroit in 1930 and started practice there in 1937. Through 1933 to 1936 he was Instructor in Urology at the University of Michigan; MS (Surgery) University of Michigan (1935). He is a member of the Detroit Urological Society, North Central Section, American Urological Association, American College of Surgeons. He was Lt. Col., Medical Department, AUS, from February, 1943, to April, 1946. Dr. Bromme is Past President of the Medical Veterans World War II, Past President of the Noon Day Study Club. He was Editor-in-Chief of the *Detroit Medical News,* 1941-42, Associate Editor from 1946 to 1948, and was appointed Editor for 1948-1949. He is a Consultant in Urology, Veterans Administration, Dearborn, Michigan; Surgeon to the Out-Patient Department, Harper Hospital; Chief of Urology Department, Woman's Hospital, Editor, *Woman's Hospital News Bulletin.*

Dr. Bromme has been very active in the work of the Wayne County Medical Society and as a member of Reference Committees of the House of Delegates of the Michigan State Medical Society.

We look forward to his career on the Council, where his shrewd analysis of problems will have plenty of opportunity for exercise.



WINFRED B. HARM, M.D., of Detroit, is the second new Councilor from Wayne County chosen by the House of Delegates, making the fourth from the metropolitan area.

Dr. Harm was born in Detroit, October 5, 1893, is married and has one son. He graduated from Dctroit College of Medicine and Surgery, now Wayne University, in 1916, served as intern at St. Mary's Hospital, Detroit, and as resident at Providence Hospital.

He served in World War I from 1917 to 1919, being in France October 17, 1917, to July 19, 1919, as Captain, MRC. After the war, Dr. Harm returned to Detroit where he is in general practice. He was editor of the *Detroit Medical News,* 1944-45, President of the Wayne County Medical Society 1916-17, and is now chairman of the General Practice Section of the American Medical Association, which he materially hclped to establish. Dr. Harm is a member of the American Academy of General Practice and is on the Board of Directors of Michigan Medical Servicc. He belongs to the Dearborn Country Club, the Detroit Yacht Club, the Military Surgeons and the Knights of Columbus. His hobby, besides the classification of General practice, is philately. He is a very active worker, not a "yes man," but a man of considered judgment.

HIPPOCRATES WAS RIGHT

Ode to a Score of Doctors

When the Oracle of Thebes blazed out in wrath
That saving lives was but defying God,
Hippocrates kept firmly on his chosen path,
Not once did one of his disciples nod.
He knew the awful power of Thebes, and fate
Was sure and swift for those who disobeyed.
"But God *is* life," he told his trusted eight,
"Keep to thy oath and do not be afraid."
"Service above self," he told them by the temple wall,
"Go forth to heal the halt, the blind, the lame!
"Somehow thou shalt receive thy bread, but all
"Must know thee by thy works, so seek not fame.
"Thy patient, though he be a slave as black as night,
"An Oriental or a golden Viking from the North,
"Rich or poor, or weak, or full of might,
"Thy aid to him shall be the measure of thy worth.
"Weigh not his purse, somehow, sometime thou shalt be paid,
"Encourage him to hope, to laugh, let joy prevail.
"Keep thou the faith with him who comes to seek thy aid;
"Without this faith, thy healing arts may sometimes fail."

• • •

You know you swore the oath of old Hippocrates,
You score or more of men we honor here tonight.
You also know how time has proved of all of these
Great men of healing science he alone was right.
Of course, by science, skill, new drugs, and new machines,
Your precious art of saving lives has been improved;
But when you pause to ponder on your present means,
You must admit by faith alone you have been moved.
You've kept this faithful trust in peace and war and though
You've worked on bloody decks of ships or battle field,
You cared not if the wounded man was friend or foe,
"Your patient, Doctor," this man's hurt and must be healed.
Our Army's first Chief Surgeon died at Bunker Hill—
Warren! But what of Shippen, Morgan, Benjamin Rush!
And brave old Mercer killed near Princeton Mill—
The mention of these doctors' names should make cowards blush.
The eve of Princeton, brave old Doctor Mercer's voice
Saying, "I lay away my scalpel for the sword.
"To lead my own brigade in battle is my choice.
"My men will follow me to hell at just one word!
"Let younger doctors treat your men," he said, "while we
"Deploy my brigade to turn the British right.
"I claim our lives mean nothing if we can't be free."
And Doctor Mercer fell, the first man in the fight.

• • •

In all wars gold stars dot your honor rolls and still
It seems that fortune, fame, and riches pass you by.
But you keep right on, you must, you always will,
Just being a good cutting doctor till you die.
You know by now your real reward lies not in fame
Nor wealth. You must have known this when you heard the call
To practice healing all the sick, the blind, the lame.
Remember Christ, the greatest healer of them all.
And so defiance hurled by old Hippocrates
At the wrathful Oracle of Thebes was not so odd;
For, Doctor, you and you alone of all of these
Can prolong human life without defying God.

EARL PARKER

The Kalamazoo Academy of Medicine, on October 5, gave a dinner to twenty of their doctors in recognition of long and devoted service. One of the citizens of Kalamazoo, a laymen, offered this Ode, and we are glad to publish it as a well-intended tribute from one who appreciates the services of the medical profession.—EDITOR.

ON THE RUN . . . . .

To evaluate completeness of removal of a chorionepithelioma or mole, repeated quantitative urine assays for gonadotropic hormone must be carried out for an extended period.

• • •

When diabetes and tuberculosis co-exist the diabetes is discovered before the tuberculosis in 65 to 80 per cent of the patients.

Selected by WILLIAM S. REVENO, M.D.

JOUR. MSMS

MICHIGAN STATE MEDICAL SOCIETY

SUMMARY OF PROCEEDINGS OF 1948 HOUSE OF DELEGATES

The 83rd Annual Session of the Michigan State Medical Society's House of Delegates was held in Detroit, September 20-21, 1948.

The House of Delegates:

1. Adopted with thanks the Speaker's address, the President's address, the President Elect's address the Annual Reports of The Council, the report of Delegates to the American Medical Association, and the Annual Report of the Commission on Health Care.

2. The reports of all Standing Committees and of all Special Committees of the Society were adopted, including that of the Legislative Committee with an instruction to The Council "That it devote strong effort to remove the block in both the Basic Science Law and the requirements of the Board of Registration in Medicine which requires licensure in both the Basic Science and in Medicine for residents in training in our State."

3. Adopted Resolutions concerning:
   (a) Creation of Committee on Geriatrics (to include work of former Committee on Heart and Degenerative Diseases).
   (b) Requisites for nurse training.
   (c) Creation of Medical Library Service.
   (d) Recognition of 46 years' attendance at House of Delegates Sessions by A. V. Wenger, M.D., Grand Rapids.
   (e) Veterans Administration Hospital in Ann Arbor.
   (f) Formation of National Agency for Voluntary Health Service Plans (amended).
   (g) Special Assessment ($25) for 1949.
   (h) Creation of 17th and 18th Councilor Districts
   (i) To increase number of medical graduates.
   (j) Resolution of Section on Ophthalmology (substitute resolution approved).
   (k) Token of esteem to E. R. Witwer, M.D., Detroit, for his services to Medicine.

4. Took action on other resolutions as follows:
   (a) *Postponed indefinitely* resolution re comprehensive practice act.
   (b) *Defeated* resolution proposing reduction in term of Councilors.
   (c) *Defeated* resolution that House of Delegates resolutions be presented 30 days prior to Session.
   (d) *Referred* the resolution re consultation of doctors of medicine with osteopaths to The Council with instruction to act.
   (e) *Disapproved* resolution re A.C.S. hospital standards.

5. (a) Adopted motion to instruct The Council to map out two new Councilor Districts.
   (b) Adopted motion setting terms of Councilors of 17th District (1953) and 18th District (1949).
   (c) Adopted motion to send best wishes to Public Relations Counsel H. W. Brenneman, ill.

6. (a) Elected 14 members to Emeritus Membership: Wm. L. Helkie, M.D., Three Oaks; N. A. Herring, M.D., Niles; G. W. Moll, M.D., Escanaba; C. M. Baskerville, M.D., Mt. Pleasant; J. R. W. Kirton, M.D., Calumet; Joseph B. Whinery, M.D., Grand Rapids; H. H. Loveland, M.D., Tecumseh; I. L. Spalding, M.D., Hudson; Herbert Wm. Landon, M.D., Monroe; Henry E. Perry, M.D., Newberry; H. B. Britton, M.D., Ypsilanti; John B. Morton, M.D., Detroit; Noah E. Aronstam, M.D., Detroit; Duncan A. Campbell, M.D., Detroit.
   (b) Elected 40 members to Life Membership: J. H. Van Ness, M.D., Allegan; R. W. McLain, M.D., Jackson; J. W. Purdy, M.D., Alpena; Charles W. Heald, M.D., Battle Creek; H. A. Herzer, M.D., Albion; W. O. Upson, M.D., Battle Creek; John C. Benson, M.D., Flint; Benjamin Goodfellow, M.D., Flint; Orill Reich-

ard, M.D., Flint; James W. Barnebee, M.D., Kalamazoo; J. B. Jackson, M.D., Kalamazoo; E. D. Sage, M.D., Kalamazoo; George L. Bond, M.D., Grand Rapids; Burton R. Corbus, M.D., Grand Rapids; Simeon LeRoy, M.D., Grand Rapids; P. B. Hardy, M.D., Tecumseh; F. A. Howland, M.D., Adrian; Benjamin L. Franklin, M.D., Remus; Lucius A. Farnum, M.D., Pontiac; Edward V. Howlett, M.D., Pontiac; C. E. Long, M.D., Grand Haven; David E. Bagshaw, M.D., Saginaw; Lewis Bracey, M.D., Sheridan; W. E. Jewett, M.D., Adrian; C. D. Brooks, M.D., Detroit; J. E. Gleason, M.D., Detroit; H. E. Grant, M.D., Detroit; G. W. Robinson, M.D., Detroit; D. L. Sherwood, M.D., Detroit; Carlos Shotwell, M.D., Detroit; Albert Wehenkel, M.D., Detroit; Walter D. Ford, M.D., Detroit; L. J. Hirschman, M.D., Detroit; C. E. Simpson, M.D., Detroit; Charles L. Washburne, M.D., Ann Arbor; W. C. Wylie, M.D., Ann Arbor; Charles C. Flinn, M.D., Allegan; G. H. Rigterink, M.D., Hamilton; Andros Gulde, M.D., Chelsea; F. A. Pratt, M.D., Kalamazoo.

(c) Elected 61 members to Associate Membership: William Asher, M.D., Ann Arbor; Arthur Allen, M.D., Ann Arbor; Charles Aldridge, M.D., Ann Arbor; Robert Berry, M.D., Ann Arbor; George R. Barry, M.D., Ann Arbor; William Brownlee, M.D., Ann Arbor; William Butler, M.D., Ann Arbor; Thomas Brill, M.D., Ann Arbor; Dolphus Compere, M.D., Ann Arbor; William Cheney, M.D., Ann Arbor; James I. Collins, M.D., Ann Arbor; W. R. Craig, Jr., M.D., Ann Arbor; M. S. DeWeese, M.D., Ann Arbor; Arthur Dalton, M.D., Ann Arbor; Eugene Donovan, M.D., Ypsilanti; Ivan Duff, M.D., Ann Arbor; Robert Fish, M.D., Ann Arbor; John K. Fulton, M.D., Ann Arbor; Devitt Gordon, M.D., Ann Arbor; Jack Gustafson, M.D., Ann Arbor; A. E. Gulick, M.D., Ann Arbor; Alex Gotz, M.D., Ann Arbor; A. A. Goldman, M.D., Ann Arbor; W. C. Hall, M.D., Ann Arbor; S. F. Horne, M.D., Ann Arbor; Raymond S. Jackson, M.D., Ann Arbor; Curtis Jones, M.D., Ann Arbor; W. King, M.D., Ann Arbor; Arnold Kambly, M.D., Ann Arbor; Harry Lusk, M.D., Ann Arbor; William Kay Locklin, M.D., Ann Arbor; Manuel Levin, M.D., Ann Arbor; Thomas Lamberti, M.D., Ann Arbor; Martin List, M.D., Ann Arbor; John R. McNichols, M.D., Ann Arbor; Tate Mason, M.D., Ann Arbor; E. W. May, M.D., Highland Park; Merle Musselman, M.D., Pittsfield Village; Ralph Mahon, Jr., M.D., Ann Arbor; Sylvester O'Connor, M.D., Ann Arbor; Max Parrott, M.D., Ann Arbor; Beverly Payne, M.D., Ann Arbor; Peter Rowe, M.D., Ann Arbor; William H. Reiff, M.D., Ann Arbor; Robert Sweet, M.D., Ann Arbor; John W. Strayer, M.D., Ann Arbor; Henry K. Schoch, Jr., M.D., Ann Arbor; Wayne Stewart, M.D., Ann Arbor; Hyman Shapiro, M.D., Ann Arbor; Madison Thomas, M.D., Ann Arbor; Arthur C. Thompson, M.D., Ann Arbor; Daniel C. Thompson, M.D., Ann Arbor; George D. Taylor, M.D., Ann Arbor; Arthur H. Ulmer, M.D., East Ann Arbor; Edwin Wright, M.D., Ann Arbor; Arnold Wollum, M.D., Ann Arbor; Keith E. Weller, M.D., Ann Arbor; William F. Weeks, M.D., Ann Arbor; Warren Weisinger, M.D., Ann Arbor; Jerome Yared, M.D., Ann Arbor; Herbert Zatzkin, M.D., Ann Arbor.

(d) Elected one member to Retired Membership: Frederick Baker, M.D., Pontiac.

7. Adopted general revision of Constitution and By-Laws, as amended.

8. C. E. Umphrey, M.D., Detroit, outlined current work of National Physicians Committee.

9. Elected:

(a) Charles A. Paukstis, M.D., Ludington, as Councilor of 11th District (1953).

(b) A. H. Miller, M.D., Gladstone, as Councilor of 12th District (1953).

(c) W. S. Jones, M.D., Menominee, as Councilor of 13th District (1953).

(d) W. B. Harm, M.D., Detroit, as Councilor of 17th District (1953).

(e) William Bromme, M.D., Detroit, as Councilor of 18th District (1949).

(f) W. D. Barrett, M.D., Detroit, T. K. Gruber, M.D., Eloise, and W. H. Huron, M.D., Iron Mountain, as Delegates to American Medical Association.

(g) R. L. Novy, M.D., Detroit, R. H. Denham, M.D., Grand Rapids, and C. I. Owen, M.D., Detroit, as Alternate Delegates to American Medical Association.

(h) W. E. Barstow, M.D., St. Louis, as President-Elect.

(i) L. C. Harvie, M.D., Saginaw, as Councilor of 8th District (1952).

(j) J. S. DeTar, M.D., Milan, as Speaker, House of Delegates.

(k) Robert H. Baker, M.D., Pontiac, as Vice-Speaker, House of Delegates.

10. Speaker J. S. DeTar, M.D., expressed thanks to hard-working MSMS officers and House of Delegates Reference Committees and personnel.

MICHIGAN STATE MEDICAL SOCIETY

Eighty-third Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

First Meeting

MONDAY MORNING

September 20, 1948

The First Meeting of the Eighty-third Annual Session of the Michigan State Medical Society, held at the Book-Cadillac Hotel, Detroit, Michigan, convened in the English Room at ten-thirty o'clock, J. S. DeTar, M.D., The Speaker of the House, presiding.

THE SPEAKER: The House of Delegates will please be in order. The Chair will ask for the report of the Credentials Committee. Dr. O'Meara.

J. J. O'MEARA, M.D.: I have in my hand the names of 94 members who have been certified by the proper officials of the different county societies as delegates to the Michigan State Medical Society. This is more than 40 per cent, which consists of a quorum, 50 per cent of which are not from any one county society.

I. Record of Attendance

OFFICE	OFFICER	MEETING 1st	2nd	3rd	4th
Speaker	J. S. De Tar	x	x	x	x
Vice Speaker	R. H. Baker	x	x	x	x
Secretary	L. Fernald Foster	x	x	x	x
Immediate Past President	Wm. A. Hyland	—	—	—	—
COUNTY	**DELEGATE**				
1. Allegan	L. F. Brown	x	x	x	x
2. Alpena-Alcona-Presque Isle	W. E. Nesbitt	x	x	x	x
3. Barry	A. B. Gwinn	x	x	x	x
4. Bay-Arenac-Iosco	A. D. Allen	x	x	x	x
	Neal R. Moore	x	x	x	x
5. Berrien	D. W. Thorup	x	x	x	x
6. Branch	R. L. Wade	x	x	x	x
7. Calhoun	B. G. Holtom	x	x	x	—
	G. W. Slagle	x	x	x	x
8. Cass	S. L. Loupee	x	x	x	x
9. Chippewa-Mackinac	B. T. Montgomery	x	x	x	x
10. Clinton	T. Y. Ho	x	x	x	x
11. Delta-Schoolcraft	W. A. LeMire	x	x	x	x
12. Dickinson-Iron	D. R. Smith	x	x	x	x
13. Eaton	G. C. Stucky	x	x	x	x
14. Genesee	J. E. Livesay	x	x	x	x
	A. C. Pfeifer	x	x	x	x
	C. K. Stroup	x	x	x	x
	A. N. Thompson	x	x	x	x
15. Gogebic	A. C. Gorrilla	Not Repstd.			
16. Grand Traverse-Leelanau-Benzie	D. G. Pike	x	x	x	x
17. Gratiot-Isabella-Clare	M. G. Becker	x	x	x	x
18. Hillsdale	L. W. Day	x	x	x	x
19. Houghton-Baraga-Keeweenaw	T. P. Wickliffe	x	x	x	x
20. Huron	C. W. Oakes	x	x	x	x
21. Ingham	R. S. Breakey	x	x	x	x
	E. J. Robson	x	x	x	x
	H. W. Wiley	x	x	x	x
22. Ionia-Montcalm	W. L. Bird	x	x	x	x
23. Jackson	C. S. Clarke	x	x	x	x
	J. J. O'Meara	x	x	x	x
24. Kalamazoo	R. J. Armstrong	x	x	x	x
	L. W. Gerstner	x	x	x	x
	W. A. Scott	x	x	x	x
25. Kent	L. C. Carpenter	x	x	x	x
	G. W. DeBoer	x	x	x	x
	R. H. Denham	x	x	x	—
	W. B. Mitchell	x	x	x	x
	Andrew VanSolkema	x	x	x	x
	A. V. Wenger	x	x	x	x
26. Lapeer	D. J. O'Brien	x	x	x	x
27. Lenawee	P. L. Miller	x	x	x	x
28. Livingston	H. G. Huntington	x	x	x	x
29. Luce	F. R. Koss	x	x	x	x
30. Macomb	D. B. Wiley	x	x	x	x
31. Manistee	E. B. Miller	x	x	x	x
32. Marquette-Alger	R. A. Burke	x	x	x	x
33. Mason	Ephraim B. Boldyreff	x	x	x	x
34. Mecosta-Osceola-Lake	J. A. White	x	x	x	x
35. Menominee	W. S. Jones	x	x	x	x
36. Midland	R. S. Ballmer	x	x	x	x
37. Monroe	T. A. McDonald	x	x	x	x
38. Muskegon	T. J. Kane	x	x	x	x
	Robert D. Risk	x	x	x	x
39. Newaygo	B. L. Masters	x	x	x	x
40. North Central Counties	C. G. Clippert	x	x	x	x
41. Northern Michigan	J. R. Rodger	x	x	x	x
42. Oakland	C. R. Gatley	x	x	x	x
	Felix Kemp	x	x	x	—
	T. H. Pauli	x	x	x	x
43. Oceana	W. G. Robinson	Not Repstd.			
44. Ontonagon	W. F. Strong	Not Repstd.			
45. Ottawa	D. C. Bloemendaal	x	x	x	x
46. Saginaw	L. C. Harvie	x	x	x	x
	C. E. Toshach	x	x	x	—
47. Sanilac	R. K. Hart	Not Repstd.			
48. Shiawassee	C. L. Weston	x	x	x	x
49. St. Clair	George Waters	x	x	x	x
50. St. Joseph	R. A. Springer	x	x	x	x
51. Tuscola	L. L. Savage	x	x	x	x
52. Van Buren	W. R. Young	x	x	x	x
53. Washtenaw	P. S. Barker	x	x	x	x
	O. K. Engelke	x	x	x	x
	B. M. Harris	x	x	x	x
	H. H. Riecker	x	x	x	x
	R. W. Teed	x	x	x	x
54. Wayne	W. W. Babcock	x	x	x	x
	L. J. Bailey	x	x	x	x
	C. J. Barone	x	x	x	x
	W. D. Barrett	x	x	x	x
	D. C. Beaver	x	x	x	x
	Wm. Bromme	x	x	x	x
	W. L. Brosius	x	x	x	x
	F. G. Buesser	x	x	x	x
	C. L. Candler	x	x	x	—
	A. E. Catherwood	x	x	x	—
	M. A. Darling	x	x	x	x
	H. F. Dibble	x	x	x	x
	Douglas Donald	x	x	x	x
	B. H. Douglas	x	x	x	x
	H. B. Fenech	x	x	x	x
	E. H. Fenton	x	x	x	x
	A. V. Forrester	x	x	x	x
	T. K. Gruber	x	x	x	x
	W. B. Harm	x	x	x	x
	C. K. Hasley	x	x	x	x
	L. T. Henderson	x	x	—	—
	L. W. Hull	x	x	x	x
	S. W. Insley	x	x	x	x
	E. D. King	x	x	x	x
	E. G. Krieg	x	x	x	x
	H. J. Kullman	x	x	x	x
	J. J. Lightbody	x	x	x	x
	G. T. McKean	x	x	x	x
	M. H. Miller	x	x	x	x
	L. J. Morand	x	x	x	x
	H. L. Morris	x	x	x	x
	R. L. Novy	x	x	x	x
	C. I. Owen	x	x	x	x
	G. C. Penberthy	x	x	x	x
	R. H. Pino	x	x	x	x
	H. F. Raynor	x	x	x	x
	W. S. Reveno	x	x	x	—
	W. F. Seeley	x	x	x	x
	E. D. Spalding	x	x	x	x
	E. C. Texter	x	x	x	x
	Arch Walls	x	x	x	x
	J. E. Webster	x	x	x	x
	F. A. Weiser	x	x	x	x
55. Wexford	R. V. Daugharty	x	x	x	x

THE SPEAKER: The roll call will be dispensed with, if there is no objection, and the report of the Credentials Committee will be considered as the roll call.

We have a few announcements before we start our business, gentlemen. I should like to invite your attention to your Handbook, page 5, on the Reference Committee on Officers' Reports. Dr. Clayton Stroup has taken the place of Dr. A. H. Kretchmar.

On the Reference Committee on Amendments to the Constitution and By-Laws, Dr. T. J. Kane has taken the place of Dr. L. E. Holly.

I regret to announce that Dr. Christian of Lansing and Dr. L. E. Holly are sick and unable to attend.

F. A. WEISER, M.D. [Wayne]: I move that this body send its regrets to Dr. Christian and Dr. Holly on their absence, and wish them a speedy recovery.

THE SPEAKER: You have heard the motion that our regrets be sent to Dr. Christian and Dr. Holly and we wish them a speedy recovery.

[The motion was seconded by R. A. Springer, M.D., St. Joseph, and carried.]

THE SPEAKER: The motion is passed and the Secretary is requested to do so.

I am going to call on Dr. Foster to make some rather important announcements at this time. Dr. Foster.

Secretary Foster: Mr. Speaker and Members of the House: The first important announcement has to do with special memberships. There seems to be a very decided confusion in the minds of many of the county secretaries as to the techniques necessary to propose members for special membership.

It must be borne in mind that according special memberships—life, emeritus and so on—is the prerogative of the House of Delegates and that because a county medical society decides to give a physician an emeritus membership and a letter is written to the Executive Office inquiring whether or not this man is eligible, that does not constitute making application for such an award.

In other words, it is necessary when a county medical society accords a special membership to one of its members and chooses to have it borne out in the House of Delegates at the state level, that the County Society secretary write to the Executive Office and say, "Is this doctor eligible for a certain type of special membership?" and we send back a letter to the secretary, saying "Yes" or "No," whichever the situation happens to be. That does not constitute the presentation of an application. That is simply giving you the information as to whether or not your candidate is eligible. The awarding of special memberships must therefore be done after your county society has filed with the State Society Secretary this morning a resolution in triplicate, signed by an officer of the county medical society, setting forth the fact that that county medical society is seeking a special membership for a certain doctor from this House of Delegates.

We have had a lot of confusion. The handing in of a request on a prescription pad does not constitute a triplicate application. The applications, according to the Constitution and By-Laws, must be in triplicate. Stenographers for this purpose will be found in Suite 500. We have here records of many men whom we have certified to the county societies as being eligible. That is all we have done. It is not our prerogative to submit an application. All we can do is tell you whether or not they are eligible, and the application must be made by the county medical society to this House of Delegates through its delegate.

The Speaker: Thank you, Dr. Foster.

Welcome To New Delegates

I should like at this time to ask those members of the House of Delegates who are here for the first time to rise.

[The members who were attending a meeting of the House of Delegates for the first time rose.]

The Speaker: Gentlemen, on behalf of the House of Delegates, I wish to welcome you, as new members of our body.

The Session of the House of Delegates is the most important of the hundreds of group meetings held during the year under the name of the Michigan State Medical Society. To this session are brought the reports of all work done by the committees, of all actions and decisions of The Council and its Executive Committee during the year. It is at this session that we elect the Councillors and Officers for the coming year.

As you will note shortly, the work of the State Society during the past year, as embodied in the annual reports, will be referred to various reference committees for consideration and criticism. All resolutions presented will be sent to committees this afternoon, for consideration. These committees will report their findings this evening, and the House will take action thereon. Every delegate has been chosen to represent his county society or 50 men of his society. I wish to urge you, as newly elected delegates, to participate freely in the discussion of our problems, to take copious notes on the questions considered, and to report fully to your constituents at the first meeting of your Society. Your county society president may not ask for your report; I urge you to take the initiative, and to make certain that the men you represent are informed fully of majority and minority opinions here expressed.

Gentlemen, we welcome you to the House of Delegates of the Michigan State Medical Society.

And one more word: I should like to request that each delegate seeking the floor state clearly his name and the society he represents, in order to facilitate the work of the House, and particularly, our stenotypist.

The next item on the agenda is the address of the Speaker, and I shall ask the Vice Speaker to take the chair.

[R. H. Baker, M.D., Vice Speaker of the House, took the chair.]

The Vice Speaker: Gentlemen of the House, it is my pleasure at this time to introduce to you the man who has just spoken, Dr. J. S. DeTar, the Speaker of the House, familiarly and affectionately known as Jack.

[J. S. DeTar, M.D., read the Speaker's Address.] [Applause]

II. Speaker's Address

It has been my privilege during the past year to represent the House of Delegates on the Council and on its Executive Committee. I deem it my duty to report to you my impressions of the year's work.

PUBLIC RELATIONS

Last year I reported to you in detail the phase of the 1947 program which I considered at that time to be the most vital as well as the most controversial of the year: the public relations program and the funds spent therefor.

During the past year we have seen an even more comprehensive public relations program carried out by a hard-working committee composed of a representative from each Councilor District, under the capable leadership of Dr. L. W. Hull of Wayne County. Mr. Hugh Brenneman has executed the decisions of the Committee most effectively, and, in addition, has provided the spark for many a new and potent idea or project. We have the finest public relations director in the entire medical field, attested by the multiplicity of requests for his services and advice from other states.

I have been amazed in reviewing the minutes of the meetings of the Council and of the Executive Committee, some of which run up to 21 closely typed pages, to note the number, variety, and scope of the problems considered. Many of these are embodied in the Report of the Council. I urge you to consider the entire report critically.

"IMPRACTICES"

From among the many problems discussed repeatedly in Council meetings, I should like to comment briefly on one which, to me, rates a high priority: the problem of "Impractices." Dr. Edward F. Sladek posed the problem to us a year ago. By "impractices" is meant refusal to give service, overcharging for service, hasty consideration of patients' problems, et cetera; all the actions on the part of physicians which act to negate our positive public relations program.

The County Societies Committee of the Council studied this problem at length. The Council approved unanimously the recognition of the fact that such breaches of medical public relations do exist, that they are acts which reflect on the entire profession. The Council recommended that the State Public Relations Committee take appropriate action to attempt to curb the so-called "impractices."

Such action was taken, on August 22. By unanimous vote of the entire public relations committee, the appointment of a subcommittee on medical mediation was requested of our President, this subcommittee to assist in adjudicating complaints of the public against Doctors of Medicine. The Public Relations Committee, by unanimous decision, then formulated a plan of action which will take one member of that committee into every county medical society in the state—armed with information, and requesting each county society to set up its own medical mediation committee for action on the county level. Pioneering in this type of public relations has been done in Colorado. In Michigan, Wayne County has done likewise. This is the first action in this state, however, on a state-wide basis, and it is long overdue. I doubt if anyone will deny that unfavorable publicity, such as has been accorded the ophthalmologists, the Roentgenologists, and the pathologists in the public press during the past few months, more than cancels out the benefits of our entire public relations program. Condemnation without knowledge of the facts is not justified. However, I venture the opinion that functioning boards of mediation on the county level, and on the state level, will do much to prevent abuses by members of the profession, and misunderstandings on the part of the layman. I hope this House of Delegates will give full consideration to this problem.

CO-OPERATION WITH LAY ORGANIZATIONS

I should like to offer a further observation on the development of the public relations program. From its initial effort of two years ago with pamphlets, newspaper and paid radio advertising, the public relations effort has grown—perhaps matured is the better word—to a live, active participation in a great variety of activities which directly or indirectly improve our rapport with the laity. I refer to such projects as the rural health survey, and the rural health conference.

I refer to the work of the Commission on Health Care, with its very effective brochure on Medical Associates.

I refer to our effort to form a Michigan Health Council.

I refer to our rheumatic fever control centers, in which we are co-operating with a lay organization, a state agency, and with a collegiate alumnae association.

I refer to the work of our cancer committee, in which we are co-operating with lay and professional organizations, pooling our efforts together.

I refer to our present effort to form a Michigan Heart Association, taking the leadership and frankly asking for lay co-operation.

All of these projects constitute practical public relations. All involve definite public service. All call for lay co-operation under medical leadership. We are spending considerable amounts of Society money on these activities, and they are worth it. They are the very essence of good public relations.

I should like to comment briefly on two parts of the program, the Rural Health Conference and the Michigan Health Council.

RURAL HEALTH CONFERENCE

One of the most pleasant forms of indoor exercise is patting oneself on the back. Our Society may well be pardoned for engaging in this pastime in connection with the rural health conference held last week in Lansing. This was our second such meeting. Participation of laymen was increased manyfold. We had 40 co-sponsors in this project.

There were 420 persons in attendance. Sixteen discussion groups spent a total of over fifty hours of spirited discussion of the ways and means of improving the health of our rural people. It was interesting to hear a farm leader say, "It is not a question of whether the farmer can afford to have Blue Cross-Blue Shield insurance; he simply cannot afford to be without it." It was a thrill to see one of our rural physicians working on the same panel with two extension professors, the State Commissioner of Health, the Executive Secretary of the Michigan Nursing Center and the head of a mental hospital, each representing a different approach to the rural health problem; and to see another rural physician working on another panel with a farm leader, the director of the Office of Hospital Survey and Construction, a charitable foundation director, and a county health department director.

This co-operative effort of Michigan physicians with 40 organizations interested in rural health ,marks a new high in practical public relations. I venture the suggestion that when organized medicine and organized labor arrive at the point where both parties can sit down together and tackle the problem of the health of union members and their families with the same frankness and co-operation and understanding that characterized the give-and-take discussions of this rural health conference, the demand for federal control of medical care will evaporate.

THE MICHIGAN HEALTH COUNCIL

There are over 150 different statewide organizations in Michigan having primary interest in the health field. There are over 5,000 active organizations in the state and practically all have some type of health committee. Their work on health problems is often duplicated and made ineffectual by lack of co-ordination, on both state and county level. The Michigan Rural Health Conference of 1947 called upon the sponsor and co-sponsors to provide for the organization of community health councils. As sponsor, this responsibility fell upon us. Since September, 1947, the history of this project has been as follows:

On November 10, 1947, our Rural Health Committee passed a resolution recommending the reactivation of the Michigan Health Council with funds totaling $22,500, with the suggestion that they be contributed equally by the Michigan State Medical Society, the Michigan Medical Service, and the Michigan Hospital Service. The resolution also called for a full-time field representative to assist in establishing community health councils locally throughout the state, and to assist in carrying on community enrollment campaigns for Blue Cross-Blue Shield enrollment.

On November 19, this resolution was approved by the Executive Committee of the Council. The Michigan State Medical Society stood ready to contribute $7,500 from our public relations funds to finance this worthwhile project.

STEERING COMMITTEE

Dr. Andrew S. Brunk of Wayne called and held an excellent pre-organization meeting with many lay organizations enthusiastically supporting the plan.

However, to date, funds have not been forthcoming from Michigan Medical Service or from Michigan Hospital Service. It is unfortunate that our progress is so slow, because other agencies are standing ready to act in the event of our failure. The special steering committee of the National Health Assembly, on July 28, announced its intention to enter this field on a national basis. When local leadership is lacking it will be provided by Washington. The Michigan Congress of Parents and Teachers was planning to establish a Michigan Health Council when we announced our intentions a year ago. The Junior Chambers of Commerce of Michigan have shown great interest. The Extension Department of the Michigan State College stands ready to take over this project.

During the panel discussions before the Rural Health Conference last week the need of local community health councils was voiced again and again, by farmers, by doctors, by educators. There were just two resolutions passed by that Conference. One delineated the functions of local community health councils, and the other urged immediate action on the formation of a State Health Council to assist and encourage the local councils. Both resolutions were passed unanimously.

As sponsors of the Rural Health Conference, our duty is clear cut. Failing to take the initiative we will again find ourselves riding in the rear seat, as has been the experience of the medical profession so often in the past.

COUNTY HEALTH DEPARTMENTS

In passing, I should like to point out another sphere of health activity in which we have failed to achieve 100 per cent coverage. Of the eighty-three counties in the state, eleven counties, or 14 per cent do not have a county health department. These counties are Berrien, Jackson, Livingston, Clinton, Ionia, Montcalm, Gratiot, Tuscola, Huron, Marquette, and Gogebic.

The Michigan State Medical Society was instrumental in the formation of the Michigan State Health Department. The State Health Department functions through organized county units with trained personnel. With no county health department the people of these counties are deprived of a full preventive health service which is their right.

True it is that the organization of a county health department rests with the people of each county. It is their right to accept or reject the idea. Yet, who has more moral obligation to lead in the campaign of health education necessary to develop public demand for better preventive health services than the physicians of the county, and the County Medical Society?

The second point in the AMA 10-point Program for National Health is the "provision of preventive medical services through professionally competent health departments."

Obviously here is a duty and an obligation to the home community which physicians and medical societies in these counties cannot postpone indefinitely. Wherever leadership in health activities is assumed by local physicians, the public relations of our profession prosper. Wherever we lag and wait to be forced into action, our public relations suffer.

CONCLUSIONS

It is impossible to review the work of the past year without arriving at some conclusions. Appraisal of our success will vary with the appraiser. My own conclusion is that we have the finest State Society in the Union,

that we have led the nation in many projects, that we contribute more than our share to American medicine in the field of pure medical science, and in the field of medical socio-economics. But we have failed to date to solve many problems. We have carried on a progressive program of public relations but we have failed miserably to prevent powerful adverse publicity which cancels our efforts. We have the largest Blue Shield enrollment in the nation, but we still cover only one-sixth of the people under Michigan Medical Service.

The great majority of our members undoubtedly render the highest type of service at fees our patients can afford to pay, but we have failed to influence or discipline the small minority whose actions cast discredit upon the profession as a whole.

We have initiated progressive physician-layman cooperative movements, but we have failed to provide local leadership, which is properly our duty in many matters of health.

The truth of the matter is that there are just not enough members of our society who are *working members.* Until our program is carried out actively on the county level—by delegates, by public relations committeemen, by secretaries and officers of the county society, we cannot hope for maximum results. However, there are some encouraging signs that we are making progress, slow as it is.

If you will allow me a minute more, I should like to quote from an address which I consider one of the most powerful pronouncements I have ever observed to come from the pen of a fellow physician. Dr. Paul R. Hawley, chief Executive Officer, Blue Cross-Blue Shield Commissions, spoke to the Conference of Presidents and other officers of State Medical Associations on June 20. He was asked to repeat the speech to the Delegates of the AMA, which he did at the opening session. These are some of the things he said:

"The dangers that threaten the free practice of medicine in this country are fast becoming critical, and still we delay in uniting in decisive action to meet them.

"We have thus far done no more than fight a series of rear-guard actions with small unorganized and uncoordinated groups. I know of no more certain road to disastrous defeat."

In speaking of the Wagner-Murray-Dingell Bill, he said, "It is my considered judgment that, if left to popular vote, this legislation might pass today. Certainly the strength mustered in its support at the National Health Assembly surprised even its protagonists, and was something of a shock to me."

In speaking of the apathy of the average physician, he said, "My heart grows heavy as I see the indifference of many physicians to the threat of freedom in medicine that is becoming more menacing each day and as I encounter the petty, selfish greed of a few physicians who would rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest. If we get socialized medicine in this country it will be organized medicine, and only organized medicine, that has brought this curse upon us. We as physicians will have only ourselves to blame. . . . All that is necessary to bring socialized medicine to this country within a very short time is for organized medicine to pursue the same course that it has pursued for the past ten years.

"Consistently negative action has brought us to this critical juncture, and has played directly into the hands of the enemies of free medicine. Time is running against us. We can no longer delay. This convention which is about to open, promises to be the most important in the hundred years of the existence of the American Medical Association. I beg of you to weigh carefully the issues that will be presented."

And that, gentlemen, is precisely the way I feel about the session we are opening this morning. We in this room have a great responsibility. I believe we will prove worthy of it.

[Applause]

[The Speaker resumed the chair.]

THE SPEAKER: The next item on the agenda is the address of the President of the Michigan State Medical Society, P. L. Ledwidge of Wayne. Dr. Ledwidge. [Applause]

III. President's Address

Once more it is time for the Society to review the work of the past year and to lay its plans for the next. Details of the things accomplished will be found in the Delegates Handbook under Committee Reports, and in the report of the Council shortly to be given by Chairman Beck. However, I should like to direct your attention to a few items some of which to date have defied accomplishment.

The matter of licensure to practice medicine in Michigan is still in an unsatisfactory and chaotic state, especially insofar as it concerns postgraduate training in hospitals. In October, 1947, the Board of Registration in Medicine, at our request, passed an administrative rule permitting graduates of Class A Medical Schools in the United States to take up to four years postgraduate training in approved hospitals and with proper restrictions without having to obtain a license to practice. In February of this year, the Secretary of the Board of Registration in Medicine advised us that he had received an opinion from the Attorney General stating that the Board of Registration in Medicine is without authority to grant such permission. So we are still up in the air.

The Basic Science Board is also involved in the question of licensure. During the year it granted reciprocity in Basic Science to the State of Iowa and agreed to study, with the help of Mr. H. H. Warner of the Governor's office, the Basic Science Laws of other states which have them with a view to further reciprocity. This whole matter demands clarification. We need more Doctors of Medicine, especially in rural areas. We need to offer our splendid hospital training facilities to the graduates of our medical schools and the medical schools of other states without the formality of license to practice during the training period. We need a reasonable reciprocity with other states for men licensed to practice in those states and for our members who may wish to practice outside of Michigan.

Somewhat over two years ago the Mercy Hospital Group withdrew its several hospitals from participation with Michigan Hospital Service in the Blue Cross plan. This was a blow to Michigan Hospital Service, to its subscribers, and to the Doctors of Medicine who care for those subscribers. In July, 1947, we were invited to join with the Michigan Hospital Association and Michigan Hospital Service in an effort to resolve this difficult problem. A Committee for this purpose was appointed. Your Committee has spent much time in this work. A great many meetings have been held and much ground gone over, but to date no definitive action has been taken. This is regrettable. We know the present situation has been most trying for many of you and for your patients. However, progress has been made and we sincerely hope that in the not too distant future a satisfactory arrangement may be reached.

Your Society is in sound financial condition. We should keep it that way. During the past three years there has been set aside from the special $25 per capita assessment a total of $100,000 over and above the cost of the extensive Public Education Program that has been carried on. This amount plus some fixed assets which have been very slowly accumulated in previous years puts us in a favorable financial position. Nevertheless, our annual dues of $12 per member will not yield sufficient funds to carry on the work of the Society as it has been done the past year without dipping into reserves or levying another special assessment. It has been suggested that the regular dues be increased and as a corollary to such increase that the special assessment be reduced or discontinued. Whether or not you wish to change the regular dues at this time and, if so, how

much, are questions to be decided by the House of Delegates.

Rather recently it has been brought to our attention that the Veterans Administration proposes to build a five hundred-bed general hospital near Ann Arbor to be operated in conjunction with the University of Michigan Medical School. This is part of a very ambitious over-all plan of the Veterans Administration to provide throughout the United States for the care of veterans, hospital facilities to a total of 300,000 hospital beds. A self-explanatory resolution on this matter will be presented to the House. It seems to us that the first two parts of this resolution are fundamental.

(1) "Resolved, that the Veterans Administration should provide veterans the best of medical and hospital care in all cases of service-connected disability, and the ultimate in hospital accommodations and equipment necessary to facilitate such care.

(2) "Resolved, that medical or hospital care in other than service-connected disabilities should be furnished our citizens at government expense on the basis of economic need only, and without reference to service with the armed forces."

Please give this resolution your most careful consideration when it is presented. This ambitious Veterans Administration program if carried to completion plus legislation designed to make families of veterans also eligible for care of nonservice-connected disabilities in these hospitals might well mean the end of the private practice of medicine in this country.

Your officers are sometimes called upon to answer such questions as these, "What are you doing about the osteopaths?", "When are you going to stop those guys practicing medicine?", and so on. You will recall that during World War II osteopaths were not commissioned to give medical care to the armed forces. Neither were they in most cases subject to the draft. The majority of draft boards exempted them to remain at home to care for the civilian population. As a consequence when many of our younger Doctors of Medicine, almost all of whom served with the armed forces, returned home after one to several years of service they found their offices rented to osteopaths and their practice gone. Naturally they were bitter, a bitterness which has not yet disappeared.

Now in answering these two questions we must keep several things clearly in mind. This is still a free country, and the patient who chooses the services of an osteopath in preference to the services of a Doctor of Medicine has a perfect right to make that choice. We have no control over the osteopaths. They have practiced under their own medical practice act entirely independent of us since 1904. That act states they may practice anything that is taught in their schools and they teach everything that is being taught in our medical schools. Whether that law is to be interpreted to mean what was taught in the osteopathic schools in 1904, or what is being taught as of now, has never been determined by the Supreme Court. We have been advised that it would not be the part of wisdom to demand a Supreme Court decision on that point.

How then are we to meet the osteopathic problem? And there is an osteopathic problem with many ramifications. It seems to us that the only sensible way is on a competitive basis in the open market to give medical care. Certainly with our superior training we should be more than able to compete with them in quality of service rendered. Just as certainly with our 4,500 members to about 900 osteopaths, a ratio of 5 to 1, we should be more than able to compete with them in making those services available. If we are to do more than this, and I am not at all sure it is wise to attempt to do more at this time, we should approach the problem with an unbiased and unselfish attitude and with the welfare of the public uppermost in our minds. The public will be served.

My obligations as President would not be fulfilled without an expression of deep appreciation to all those who have co-operated to make the year's work a success. My gratitude goes out to every member of the Society. The committee work has been unusually good. Committee members are the ones who do the most work for the least credit. I wish to thank in a special way the Council, the Committees, Secretary Foster, Executive Secretary Bill Burns and his office personnel, our legal counsel, Joe Herbert, and our public relations counsel Hugh Brenneman, all of whom have contributed much to making the year a profitable one for the Society and a pleasant one for me. I want to thank especially, too, the members of the House of Delegates who have shown me so many courtesies throughout the years.

The hours spent and the friendships made in Society work shall be to me a source of lifelong satisfaction and pleasure. The Michigan State Medical Society is truly a great organization.

[Applause]

The Speaker: Thank you, Dr. Ledwidge.

The next item on the agenda is the address of the President-Elect, Dr. Edward F. Sladek of Traverse City. I am pleased to present Dr. Sladek.

E. F. Sladek, M.D.: Mr. Speaker and Members of the House of Delegates: The Speaker and the President and myself did not consult each other previous to making our presentations here. You have heard two speakers cover a group of subjects, a group of problems, and I have another group of problems to present.

IV. President-Elect's Address

You have heard much about the problems and accomplishments of the Michigan State Medical Society. It is a great institution, looked up to and envied by all other medical societies. They look to us for leadership, for new ideas, and for counsel in solving their own problems. Why is this so? Michigan physicians do have an interest in organizational affairs, and do show a willingness to devote time to study and solve not only problems facing Michigan Medicine but also those that have a national significance. During my years of service in the Michigan State Medical Society it has been a constant source of surprise and satisfaction to see many a newly appointed committee member take hold and devote an extraordinary amount of energy to his new job in organized medicine. As long as we can discover such talent amongst our membership, we can feel sure that the many problems facing medicine will be in safe hands.

As your incoming President, I would like to review with you a few of the problems facing the Michigan State Medical Society.

BLUE CROSS-BLUE SHIELD PLANS

During the past ten or more years medicine has faced the threat of governmental political medicine. We, as an organized profession, have not simply opposed the efforts of social reformers to foist political medicine on our people, but have forged ahead and through our own efforts, trials, and tribulations, have developed a system of medical care based upon the voluntary pre-payment insurance principle. By the simple fact that the doctors of this country have shown real interest in the welfare of the patient, and have developed, and put into operation, our Blue Cross-Blue Shield Plans for taking care of costly illness, we have repeatedly postponed the possibility of the implementation of political medicine.

In doing so, we, as a medical profession, have accepted a great public trust, one which is national in scope. To justify this public trust, there still remain many things to be done. We must tell the people about Blue Cross-Blue Shield, pointing out its many advantages over compulsory schemes for providing medical care and commercially developed plans. It is imperative that a much greater enrollment of subscribers be obtained in the very near future. There must be a closer association between state plans with the development of a uniform policy for the large industrial purchaser. Greater efforts must be put forth to sell our own doctors on the ideology and advantages of Blue Cross-Blue Shield; they must become participating physicians. And, finally, the American

Medical Association must be urged to put forth greater energy in support of these plans.

UNION HEALTH FUNDS

Union health funds are an established fact. Supposedly these funds are to be used to give the member certain social security benefits to supplement those granted by the government; to cover the gap in complete security for the worker. One of these benefits is complete medical, surgical, and hospital care for the worker and his family. At the present time, these are partially covered by prepayment plans, usually on a payroll deduction system, either in Blue Cross-Blue Shield or in commercial companies. Union leaders insist that none of the existing plans are satisfactory because they do not give the worker *complete* sickness protection. Should we, as a medical profession, attempt to develop a medical care plan which is more acceptable to the union? Such plans would involve higher income limitations, possibly $4,000, increased costs to the worker and employer, and consequent increased payments to physicians, possibly 50 per cent above the present fee schedule. This requires considerable study, especially in view of the fact that the ultimate objective of union officials is a compulsory governmental tax-supported system of medical care.

If we do not develop such an expanded plan, we are faced with two possible alternatives; first, that the unions may enter the health insurance business, build company hospitals, and hire doctors at part-or-full-time salaries; or secondly, the possibility of a tremendous country-wide union-stimulated pressure movement in favor of governmental compulsory health insurance. Do we want either of these? Think seriously about this.

ORGANIZATION

Many of our members do not know what is going on or they find out about an activity too late to give maximum support. The Journal, the Secretary's Letters, the PR By Lines are not read as thoroughly as they should be. Often information is not brought before county medical societies in as forceful, explicit, or prompt a manner as seems desirable. The Secretaries' Conference, held each January, is an effort to bring information on Medical socio-economic problems directly to key-men of county medical societies, in the hope that they in turn will enthusiastically carry back this information to their local membership. This effort is only partially successful, in that enthusiasm soon wanes and is lost in the routine of medical practice.

Your officers have repeatedly offered to hold Organization Seminars with officers and members of local county medical societies. During the past year, only one such seminar was held. This should be corrected, and part of your job, as delegates, is to see to it that your county society requests such a seminar, for these seminars can do much to make up the deficits of which I have spoken.

Recent graduates and new members of our society have little knowledge as to what the society means to them, the benefits they derive from membership, nor what the society has accomplished in the interest of the health of the people and in the interest of the general membership. Should we have some sort of an Indoctrination Course or Meeting, sponsored by each county society or councilor district, with special efforts made to induce new members to attend? It might be possible that such an Indoctrination Course could be held at the same time as the Organization Seminar. Even some of our older members might benefit by attendance!

Efficiency of an organization partly depends upon the place in which the employes work. Overcrowding and widely separated departmental offices hinder the rapid, smooth production of work. Such a condition exists in the office of the Michigan State Medical Society. Additional office space in Lansing is at a premium. I believe that it is imperative that purchase of a home, the obtaining of a long term lease on a building which could be converted into office and conference space, must be considered immediately. The cash reserves of the Society used in this fashion would be more remunerative to the Michigan State Medical Society than the return from bank deposits.

PROFESSIONAL SERVICES

In attempting to analyze just what part of our population could receive a higher standard of medical care, it is evident that the infant and the child are fairly well covered. The work of the various committees of the Michigan State Medical Society in co-operation with the Michigan Department of Health and local County Health Units have stimulated the doctors of the state into performing a meritorious feat in the prevention of communicable diseases. The pioncering program of the Rheumatic Fever Control Committee, in co-operation with the Michigan Society for Crippled Children and Disabled Adults, has accomplished much in assisting in the discovery and treatment of the victims of this disease. The Crippled Childrens' Commission is doing an outstanding service for the indigent crippled and afflicted child; no hardship or indigent child need go without medical, surgical or hospital care in this state.

But, are we not missing an educational opportunity in the periodic complete physical examinations of school children? Such examinations, and the correction of defects found, would instill into this impressionable age a sense of importance of the health checkup, an impression which would continue throughout life. In order to be effective, such examinations should and must be done by the family physician.

In the same category physicians should become interested in high-school athletic contests, and see to it that a doctor of medicine be officially present at all such contests. This could be a project for each county medical society.

Greater diagnostic services and the great improvements of our rapidly advancing science in the treatment of acute and chronic illness have materially affected morbidity and mortality of disease. Greater interest in mental hygiene and psychiatric care as applied to the treatment of the private patient is paying dividends in a satisfactory medical service.

But, the indigent still lack a desirable standard of medical care. This is a responsibility of local government. No great efforts have been put forth to make county officials realize the seriousness and costs of insufficient or emergency medical services.

Medical science has produced a new problem for medicine. Now people live longer and the profession is confronted with the greater incidence of the degenerative diseases. Geriatrics has many facets, not the least of which are the social implications. With little or no study of actual needs, government has arbitrarily set the standard of living for these old people, through minimal old age assistance and social security benefits. Medical needs are largely secondary if not actually ignored. Should a committee of the Michigan State Medical Society study this problem?

Gentlemen: these are but a few of the problems confronting us. Yet, through co-operative action of our various committees and our members, we can move forward toward the solving of these and other problems and develop in Michigan a satisfactory answer to health care. Then we can tell the people about our success. If we do these two things, we will have developed the strongest bulwark against any radical change in our present forward march toward keeping Michigan leading the way in health programs. Only in this manner can we stop the attempted substitution of a compulsory retarding system of politically controlled medical service.

THE SPEAKER: Thank you, Doctor.

Before the next item on the agenda comes up, I should like to announce that I am appointing Dr. C. G. Clippert, of Grayling, of the North Central Michigan Medical Society, to act in place of Dr. Charles Kennedy of Wayne on the Reference Committee on Ethics.

The next item on the agenda is the Annual Report of The Council, and before Dr. Beck renders the supplemental report I am going to ask Secretary Foster to comment on the Annual Report of the Council, which you will find on page 47 of the Delegates Handbook.

V. Annual Reports of the Council

SECRETARY FOSTER: Mr. Speaker and Members of the House: The Council requested that the first report of The Council as appearing in the Handbook be given to you somewhat by title to save time and to prevent our having to listen to all this which was written in detail.

The original report will be brought up to date by the Supplemental Report of The Council, which will be given by Dr. Beck.

[The Secretary then summarized, briefly, the Report of The Council as published in the Handbook.]

THE SPEAKER: Since there have been several meetings of The Council held since the time that this report was issued, I will call on Dr. O. O. Beck, the Chairman of The Council, to give us The Supplemental Report of The Council. Dr. Beck!

SUPPLEMENTAL REPORT OF THE COUNCIL

1. *Membership*—The membership of the Michigan State Medical Society as of September 10, 1948, totals 4,822 including 285 Military and Special Members who are relieved from paying dues and assessments.

2. *Finances*—The Constitution of the Michigan State Medical Society charges The Council with administration of the funds of the Society, and the Treasurer with responsibility for safekeeping of the Society's invested funds.

Following the mandate of the Constitution, The Council has caused an "annual audit to be made of the funds of the Society by a certified public accountant." The report of Ernst & Ernst, for the year 1947, was published in the March, 1948, issue of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, beginning at Page 325. On Page 324 of the same Number of THE JOURNAL is a copy of the MSMS budgets for the year 1948. The audit of Ernst & Ernst is and always has been open for inspection by any member of the Michigan State Medical Society who may call at the Executive Offices, 2020 Olds Tower, Lansing 8.

The report of our auditor for the first eight months of this year (that is, to September 1, 1948) of income, expense, and accounts receivable is as follows:

INCOME AND ACCOUNTS RECEIVABLE: (Jan. 1 to Sept. 1, 1948)		
Society Dues	$ 47,289.35	
Journal Subscriptions (Allocated from dues and others)	7,045.40	
Advertising Sales, Reprints and Cuts	29,602.42	
Public Education Fund ($25 assessment)	112,593.75	
Annual Session Income	13,435.00	
Postgraduate Clinical Institute Income	7,635.00	
Rheumatic Fever Fund Income	21,421.73	
Liquidation of Trustee Account	4,462.84	
Interest and Miscellaneous Income	346.25	
Total Income and Accounts Receivable to 9/1/48		$243,831.74

EXPENSES: (Jan. 1 to Sept. 1, 1948)		
Administrative and General	$ 27,261.28	
Society and Committee Expense	20,869.43	
Public Education Expense	67,293.07	
Transferred to Public Education Reserve	40,000.00	
Journal Expenses	30,544.81	
Annual Session Expense to 9/1/48	3,378.93	
Postgraduate Clinical Institute	5,305.10	
Rheumatic Fever Expense to 9/1/48	11,646.35	
Total Expenses to 9/1/48		$206,298.97
Balance cash and Accounts Receivable 9/1/48		$ 37,532.77

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BOND ACCOUNT: (Ernst & Ernst Report as of 12/31/47)		
(a) Bonds held for General Purposes:		
Canadian Pacific Railroad Company	$ 2,000.00	
Detroit Edison Company	2,000.00	
Grand Rapids Affiliated Corporation	1,000.00	
New York Central Railroad Company	2,000.00	
Southern Pacific Company	1,000.00	
United States Savings Bonds, Series G	33,600.00	
United States Savings Bonds, Series D	1,300.00	
United States Savings Bonds, Series F	3,700.00	
United States Treasury 2½% Bonds	8,000.00	$ 54,600.00
(b) Bonds held for the Public Education Program: United States Savings Bonds, Series G	30,000.00	
Total Bond Account 9/1/48		$ 84,600.00

CASH AND ACCOUNTS RECEIVABLE AS OF 9/1/48:		
Checking Account	$ 79,379.46	
Petty Cash	11.00	
Savings Accounts (Earmarked for Public Education)	70,023.13	
Accounts Receivable	3,604.21	
Total Funds available as of 9/1/48:		$153,017.80

ESTIMATED BUDGET FOR 1949

As stated in the Annual Report of The Council (in Item 13 on page 45 of the Handbook, under "Committees"), the Michigan State Medical Society Committee on Dues Structure—composed of O. D. Stryker, M.D., Chairman; H. F. Dibble, M.D.; C. R. Keyport, M.D.; G. C. Penberthy, M.D.; and W. Z. Rundles, M.D.—found that state medical societies throughout the country relied upon adequate *dues*, without special assessments, to carry on their necessary activities. For example, one state medical society has $60 dues; four have $50 dues; one has $42. dues; two have $40. dues; three have $35. dues, and so on. Only two states have dues as low or lower than the Michigan State Medical Society.

It is the desire of The Council to discontinue assessments and to recommend that the State Society dues be set at a figure which will pay for all the services needed and desired by the membership. If the House of Delegates decides to set the 1949 dues at $35, estimates of the probable budgetary items for 1949 are:

ESTIMATED INCOME:		
1949 Dues (4,500 members at $35.00)		$157,500.00
(Allocated $13.50 to General Fund)	$60,750.00	
(Allocated 1.50 to Journal)	6,750.00	
(Allocated 15.00 to Public Education Fund)	67,500.00	
(Allocated 5.00 to Building Fund)	22,500.00	
Advertising Sales, Reprints and Cuts	43,000.00	
Annual Session Income	14,000.00	
Postgraduate Clinical Institute	7,600.00	
Rheumatic Fever Fund	21,500.00	
Interest and Miscellaneous Income	1,500.00	
Total Income:		$245,100.00

ESTIMATED EXPENSES:		
Administrative and General	$ 30,200.00	
Society Expense	11,500.00	
Committee Expense	16,550.00	
Estimated Public Education Expense	87,900.00	
Journal Expense	45,750.00	
Annual Session Expense	13,200.00	
Postgraduate Clinical Institute	6,500.00	
Rheumatic Fever Expense	21,500.00	
Building Expense	12,000.00	
Total Expense:		$245,100.00

Please note that the Public Education income (based on a per member allocation of $15. of the $35. dues) would be $67,500., while its expenditures (per the Public Education Committee's recommended budget) would be $87,900. Therefore, either the $5. allocated for the MSMS Building Fund must be utilized for Public Relations or some of the vital work of public education must suffer at a time when this endeavor is most indicated.

3. *Public Education Account*—this fund, accumulated from the special $25. assessment levied by the 1947 MSMS House of Delegates, has been used exclusively for public relations and public education purposes, as indicated in the following accounting for the first eight months of 1948:

PUBLIC EDUCATION ACCOUNT
FINANCIAL REPORT
Jan. 1, 1948 to Sept. 1, 1948

INCOME:		
Balance on hand January 1, 1948	$ 10,793.96	
Income in 1948 ($25 assessment)	112,593.75	
Total Funds available for 1948 as of 9/1/48		$123,387.71

EXPENSES TO SEPTEMBER 1, 1948:	
Salaries	$ 8,269.89
Rent and Light	346.45
Telephone and Telegraph	852.78
Printing, Stationery and Supplies	797.34
Postage	1,307.96
Equipment	461.89
Travel Expense	1,301.97

Public Relations and Secretaries Conference	3,077.58	
Purchase of Pamphlets	4,710.19	
Radio	21,007.58	
Cinema	11,648.14	
Newspaper	9,519.63	
Commission on Health Care	1,067.73	
Second Rural Health Conference to 9/1/48	442.48	
Conference of Presidents	50.00	
Sex Education	602.92	
Committee Meetings	677.49	
Miscellaneous	1,151.05	
Total Expenses to 9/1/48		$ 67,293.07
Sub-Total: Balance of funds 9/1/48		$ 56,094.64
TO PUBLIC EDUCATION RESERVE, 1948:		$ 40,000.00
Balance on Hand 9/1/48		$ 16,094.64
Estimated Expenditures to 12/31/48 as per budget:		$ 20,481.14

* * * *

PUBLIC EDUCATION RESERVE FOR EMERGENCIES:		
As of December 31, 1947:		
Savings Accounts	$ 30,000.00	
United States Savings Bonds, Series G	30,000.00	$ 60,000.00
To Public Education Reserve during 1948:		
Savings Accounts		40,000.00
TOTAL PUBLIC EDUCATION RESERVE FOR EMERGENCIES 9/1/48:		$100,000.00

You will note that, following the instruction of last year's House of Delegates, a reserve for emergencies has been created this year. The House of Delegates requested that $30,000 be set aside, but through careful planning and allocations, The Council has been able to ear-mark $40,000 out of 1948 income for the public education reserve account.

Estimates of the probable income and expenditures for the 1949 public relations and public education program, as projected by the Public Relations Committee on August 22 and approved by The Council yesterday, are as follows:

ESTIMATED PUBLIC RELATIONS EXPENDITURES FOR 1949

(Budget as adopted by Public Relations Committee 8/22/48)

I.	Administrative Expense:	
	Salaries	$ 16,000.00
	Office Rent and Light	600.00
	Printing, Stationery and Supplies	1,000.00
	New Equipment and Repairs	200.00
	Postage	1,000.00
	Telephone and Telegraph	1,200.00
	Travel Expense	2,200.00
II.	Radio: "Tell Me, Doctor"	19,000.00
III.	Newspapers: Advertising:	12,000.00
IV.	Cinema:	20,000.00
V.	Publications and Pamphlets:	5,000.00
VI.	Display:	1,000.00
VII.	Organizational:	
	Committee Meetings	1,200.00
	National Meeting Expense	500.00
VIII.	Schools: Sex Education and Libraries	200.00
IX.	Other Activities:	
	Clipping Service	300.00
	Commission on Health Care	1,000.00
	Rural Health Conference	1,500.00
	Annual County Secys. and P. R. Conference	3,000.00
	Miscellaneous General Expense	1,000.00
TOTAL ESTIMATED PUBLIC RELATIONS EXPENDITURES FOR 1949:		$ 87,900.00

4. *Information to the Public.* May we remind all medical men that the public does not love us because we do good things. Rather, public thinking is the result of (1) the good deed, plus (2) the interpretation of the deed. Each is ineffective without the other. This necessitates a continued effort on the part of the individual doctor to carry on the highest traditions of his profession plus a never-ending public relations and public informational program which, beginning in the doctor's office must continue through society effort, using every reasonable medium to carry the true facts, figures and principles of medical socio-economics into the minds and hearts of all the people.

"Those who would maintain the status quo are invariably defeated" recently stated John Foster Dulles. The best defense of freedom lies in an active offense of the right variety. We feel we have such an offense in our MSMS public relations program if it is given the personal conscientious support of each and every one of our members. We must continue to improve—to show dramatically that we are solving our problems—and stand strong against attack.

5. *Professional Relations.* (Ad libbing by Chairman Beck on breaches of medical public relations).

The Council feels that these problems and others of like character should be considered as breaches of medical public relations. Every county medical public relations committee or other designated committee should deal with and adjudicate such complaints. Moreover, the Michigan State Medical Society Public Relations Committee offers its assistance and advice to the local committees; its Subcommittee on Mediation, together with the Michigan State Medical Society Secretary, is preparing pertinent information on these problems to be presented confidentially to the memberships of county and district medical societies at future meetings to be called by the Councilors.

6. *Michigan Medical Service.* An up-to-date report on this corporation, including finances, will be presented to you at the meeting of Michigan Medical Service membership today, at 2:00 p.m. in this room. All MSMS Delegates are members of the Michigan Medical Service Corporation.

7. *Michigan Hospital Service.* The Special Committee of The Council is still working on the Michigan Hospital Service-Mercy Hospitals matter. Discussions are continuing and some progress is being made. It is hoped that the ensuing year will see the solution of this problem, for the benefit of the public.

8. *Second Michigan Rural Health Conference.* This important meeting sponsored by the Michigan State Medical Society and 41 co-sponsoring organizations, was held September 16-17, 1948. The meeting proved to be a high accomplishment in public relations with our Michigan rural groups. The Rural Health Conferences should be continued, annually.

9. *Full-Time Medical Co-ordinator for Rheumatic Fever Control Centers.* The Council has authorized the investigation of availability, qualifications, and salary requirements of a full-time Medical Co-ordinator for the pioneering Michigan State Medical Society Rheumatic Fever Control Program. A qualified pediatrician has been secured and will begin necessary work in the twenty-nine Rheumatic Fever Centers throughout Michigan as of January 1, 1949. The program is now too large and too important to continue without expert and close supervision.

The thanks of the Michigan State Medical Society are due and sincerely expressed to the Michigan Society for Crippled Children and Adults, Inc., for its generous patronage of the Michigan Rheumatic Fever Control Program during the past three years.

A recommendation on this subject follows.

10. *Michigan Heart Association.* Recently The Council appointed a Committee and authorized it to meet with representatives of the American Heart Association to discuss the Michigan heart and rheumatic fever program and future co-operation with the American Heart Association. Also The Council approved the formation of a Michigan Heart Association and hopes that it may become an affiliate of the American Heart Association; the President was authorized and has appointed a committee to form a Michigan Heart Association as soon as possible.

11. *Beaumont Memorial on Mackinac Island.* Restoration of the Mackinac Island building where Dr. William Beaumont made a significant contribution to the world's medical history 126 years ago and creation of this landmark into a Beaumont Medical Shrine are recommended by the Michigan State Medical Society Beaumont Memorial Committee and the Michigan Mackinac Island

State Park Commission. Approximately $30,000 is needed to build a historical shrine for the doctors and the people, which after erection will be permanently maintained by the Park Commission. The Michigan State Medical Society Beaumont Committee and The Council approve the plan to raise funds by popular subscription and establish the Beaumont Shrine on Mackinac Island.

A recommendation on this subject follows.

12. *Proposed Veterans Administration Hospital in Ann Arbor.* The plans to build a 500-bed Veterans Administration Hospital in Ann Arbor were discussed by The Council in July. The number of hospital beds available in Veterans Administration hospitals for service-connected cases are already far in excess of present need of or any demand which may be reasonably anticipated. Indeed, the great majority of patients in these hospitals are said to be persons who have no service-connected disabilities or illnesses whatever. The Council views the ambitious and unnecessary Veterans Administration hospital building program as a waste of public funds and the entering wedge of government control of medicine and a definite encroachment on the private practice of medicine. It must become a matter of grave concern to medical practitioners and taxpayers. The Council has been informed that a resolution covering this subject, approved by its Executive Committee, will be presented to the House of Delegates today.

13. *New Home for Michigan State Medical Society in Lansing.* The overcrowded condition of the Executive Office in Lansing has reached a point where the high efficiency of the staff is definitely hampered. The Special Committee appointed by The Council to seek a home or building that might be used for the Executive Offices has carefully searched the ground, but Lansing is unusually bereft of appropriate housing facilities, and the year's search by the Committee had been in vain until recently. A building of generous size close to the Capitol may be available in the near future. The Council is now endeavoring to negotiate a purchase or lease of this property.

The need for a Building Fund, to purchase a building with sufficient space and dignity for the Michigan State Medical Society, is indicated.

A recommendation on this subject follows.

RECOMMENDATIONS

We respectfully invite to your attention the four recommendations in the original report of The Council printed in the Handbook on page 54. They read as follows:

The Council recommends:

1. That the House of Delegates again urge, with emphasis, that all component county and district medical societies—which have not already taken effective action—should make every effort at the earliest possible moment to negotiate necessary revisions in schedules of benefits covering governmental wards so that individual members of county or district societies are not penalized by being forced to perform services at a financial loss and below the fees either charged private patients in their particular area or those indicated in the Uniform Fee Schedule for Governmental Agencies. (The county contractual clause in the Afflicted-Crippled Children Acts limit the Michigan Crippled Children Commission, by law, to payment of the county fee, where it is *less* than the Michigan Crippled Children Commission fee schedule.)

2. That the Michigan Foundation for Medical and Health Education, Inc., receive greater help and financial support from doctors of medicine in Michigan, to the end that the profession shall show the public and health-minded laymen that it is leading the way in this salutary endeavor. Only in this way will laymen become interested in making substantial contributions to the Foundation.

3. That Organization Seminars be arranged by county and district medical societies in all parts of Michigan during the ensuing twelve months. Through these local meetings the officers of the Michigan State Medical Society can bring to the membership—in an intimate, personal manner—confidential information on the state of the profession.

4. (As re-worded by The Council) is:

That the annual dues of the Michigan State Medical Society be set at $35 per member for the year 1949 to include necessary appropriations to the MSMS General Fund, the public education department, and a vitally needed Building Fund.

5. That the Michigan State Medical Society, in co-operation with the Mackinac Island State Park Commission, proceed with proper plans for raising of funds by popular subscription to restore the old Beaumont building known as the Early House on Mackinac Island and to create it into a "Beaumont Medical Shrine."

6. That the House of Delegates place on its record a vote of true thanks to the Michigan Society for Crippled Children and Adults, Inc., for its high co-operation and help to the Michigan State Medical Society during the past three years in the conduct of the Michigan Rheumatic Fever Control program which has proven to be of inestimable benefit to thousands of children in Michigan.

Respectfully submitted,

O. O. Beck, M.D., Chairman
W. E. Barstow, M.D., Vice Chairman
C. E. Umphrey, M.D.
P. A. Riley, M.D.
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
T. E. DeGurse, M.D.
E. A. Oakes, M.D.
F. H. Drummond, M.D.
R. H. Holmes, M.D.
A. H. Miller, M.D.
W. H. Huron, M.D.
D. W. Myers, M.D.
E. A. Osius, M.D.
J. S. DeTar, M.D.
P. L. Ledwidge, M.D., President
E. F. Sladek, M.D., President-Elect
L. Fernald Foster, M.D., Secretary
A. S. Brunk, M.D., Treasurer

The Speaker: Thank you, Dr. Beck.

The next item on the agenda is the Report of the Delegates to the American Medical Association. Our delegates to the American Medical Association have a heavy responsibility in carrying the progressive attitude of the Michigan State Medical Society to a somewhat more conservative body. Our delegates are W. D. Barrett, T. K. Gruber, C. R. Keyport, L. G. Christian, and W. A. Hyland—and R. L. Novy this year, who took Dr, Hyland's place.

I would like to call on Dr. Barrett to give the Report of the Delegates to the American Medical Association.

VI. Report of Delegates to AMA House of Delegates

W. D. Barrett, M.D.: Mr. Speaker and Members of the House of Delegates: Dr. Christian is sick, as you have been told, and I was notified on Saturday that I had to give this report, so I will have to give it to you from notes.

The complete report is published in the July 3, July 10, and July 17, *Journal of the American Medical Association* and covers a total of thirty-nine pages. I will not read them.

The meeting was in June, in Chicago. Dr. Hyland's brother was sick. Dr. Hyland was not there for that reason, and his place was taken by Dr. Novy.

The Distinguished Service Award was voted to Dr. Isaac Abt, of Chicago, for his outstanding work in pediatrics. He was voted over Blalock of Baltimore and Seale Harris of Birmingham, Alabama.

The Speaker of the House, Dr. Fouts, spoke of the geriatric problem which has been mentioned here today. But this was a different type of problem than was mentioned in several of the medical journals, but it is the geriatric problem of the AMA. Dr. Fouts did not think that he agreed with all the statements that had been made.

The President, Dr. Sensenich, stressed the continued

public relations of the highest caliber, the value of medicine to society, especially the free medicine, such as we have in this country, as against politically controlled. He spoke of the Brookings Report, which, as you all know, was definitely in favor of the voluntary system. He also mentioned the fact and appreciated the fact that Congress had passed the draft bill, deleting the part with reference to the drafting of physicians, but also stressed the fact that the armed services need medical help.

Rear Admiral Swanson, Surgeon General of the Navy, stressed the need of medical officers and hoped that American medicine would be able to supply these without the need of the draft of the profession.

The message from the British Medical Association, delivered by Dr. R. Scott Stephenson of London, brought greetings from the British Medical Association and hoped that we would be able to defend ourselves from political medicine and thanked the American profession for its support of the World Medical Association, whose headquarters will be in New York City.

Greetings were also received from the American Dental Association, by Dr. H. B. Washburn of Saint Paul, their president.

Dr. Lull, the Secretary, spoke of the labor difficulties that they had had during the past year and hoped that these would soon be settled, as we understand they have been now.

The Committee on Intern Placement was against the one-year internship unless it was a rotating system. As you know, some hospitals in the East have a straight internship for medicine or for surgery, instead of a rotating internship, which at times does cause trouble with boys coming from one state to another.

The Joint Committee in Co-ordination with Medical Activities had no published opinion. It is simply a group that exchanges ideas.

The Council on Medical Education and Hospitals does not appear to have the power that it would seem it should have. They appear to be afraid of what the Federal Courts might do should they try to enforce certain things. Personally—and it is only my own personal opinion—I think they are ducking an issue that the AMA should take over.

Specialty boards came in for their usual leveling. That seems to continue.

There was a general resolution on the Blue Cross, with criticism of headquarters for changing to a commercial company. By the way, Rhode Island brought in two resolutions in favor of the commercial companies. Dr. Novy very actively defended the Blue Cross at this committee hearing, and I noticed when they came out of the committee room they all looked as if they had had a pretty rough time. It continued on into the luncheon hour, but, as you know, the resolution requested that as soon as possible the insurance be transferred back to the Blue Cross plan.

Dr. Shirley brought in a unique resolution on strikes and subversive attitudes of interns and residents. This was passed.

The Woman's Auxiliary: A resolution asking that the state pay the dues so that every wife would be a paid-up member was passed.

This took me back to a year ago, or a little more than a year ago, when Dr. Holman Taylor was discussing a motion that was brought in, directing the Woman's Auxiliary. He stood up and, in his quaint Texan way, drawled, "I do not think that you can direct women; I would advise you to advise them."

The Blood Bank came in for quite a going over, especially by the men from Honolulu. They feel very definitely, and the resolution was passed, that everything should be done to support blood banks; also that where blood is supplied from blood banks, if people can afford it they should pay, that the level should be the county level for the policy that should be determined.

Medicine has many friends who are not actively engaged in the practice of medicine. One is General George E. Armstrong, Major General of the United States Medical Corps. He is definitely a friend and is working toward the elevation of the reserve officers' rank where possible, equivalent to the Regular Army. The Navy, of course, has not been quite as strong that way, but, as you all know, Dr. Paul R. Hawley is definitely a friend of the medical profession.

There were executive sessions, the same as we have here. Dr. Hawley's address was given before the General Practice Group, before the AMA delegate's meeting, in public, and then was given in executive session before the AMA delegates. I don't know why.

There was one very interesting resolution brought out, showing that sometimes the attitude of the Board of Trustees is that they do not want to go along, seemingly, with the profession as a whole but have their own ideas, and consequently sometimes there is a little bit of a disturbing element that creeps in and controversy arises. It did with regard to a resolution that Dr. Read of Atlantic City brought in, that on the Council of Medical Education one private practitioner be appointed. The Board of Trustees objected to that—that is, Dr. Henderson and Dr. Bauer did. Dr. Dwight Murray was at the meeting and he did not object.

The question that Dr. Read brought up was that a lot of education of interns and residents is not done where teaching is done, otherwise in medical schools, and consequently he felt that one private practitioner should be on that Council. The resolution was passed, stating that one private practitioner would be on that Council, who was not connected with the medical school or a teaching institution.

The new Constitution and By-laws were passed. When they were passed, Dr. Gruber said to one of the members of the Board of Trustees, "In about fifteen minutes you will have several new resolutions." In about two minutes there were twelve, changing the Constitution and By-laws.

Dr. Ernest E. Irons, of Chicago, was elected President-Elect; Dr. Roy W. Fouts, Omaha, ex-Speaker, was elected Vice President. The speaker was Dr. Frank F. Borzell, Philadelphia. The Vice-Speaker was Dr. James R. Reuling of Bayside, New York. The new Trustees are Dr. Gunnar Gundersen of La Crosse, Wisconsin, Dr. Edwin S. Hamilton of Kankakee, Illinois. The election of Dr. Hamilton of Illinois was rather a fighting affair. Illinois has to have one member on the Board of Trustees on account of the location of the headquarters, so they couldn't decide themselves. I think they had nine delegates, and four were for Dr. Warners and four were for Dr. Hamilton, and the ninth man did not vote. So they referred it to the Board of Trustees. Also, Dr. Walter B. Martin of Norfolk, Va., was elected a Trustee.

Dr. Bedell of New York was retired after being a member of the House of Delegates for thirty-three years. Dr. Burt R. Shurly of Detroit was also retired, after being a member over 30 years.

The new Board of Trustees, it would seem, is a Board of Trustees that will not try to do things that it feels the profession as a whole will not approve.

The meeting was an excellent meeting, and there was much more harmony, it seemed to me, than there had been in the two previous meetings that I have attended.

Thank you very much.

THE SPEAKER: This report will be referred to the Committee on Officers' Reports, as will Items 5, 6 and 7. Item 8 will be referred to the Reference Committee on Council Reports.

Gentlemen, we have several items on our agenda which it is necessary to take care of this morning. Dr. Robert L. Novy, President of the Michigan Medical Service, is very anxious that all delegates attend the meeting of the Michigan Medical Service Corporation this afternoon, because some very vital questions are coming before that meeting. That meeting will take place at about two o'clock, or before, if possible. All delegates will be given luncheon in this room as guests of the Michigan Medical Service. Gentlemen, I have a very great surprise for you. Dr. Pino says that the report of the Commission on Health Care will be limited to three minutes. I am, therefore, very glad to introduce Dr. Pino.

VII. Report of Commission on Health Care

R. H. Pino, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: There are a few mistakes in the report as printed in the Handbook, but they are very small, so I will not in these three minutes mention them at all.

I want to call your attention, however, to a very grievous mistake on page 2, having to do with nursing. I am telling this to you only for the reason that you might explain this to anyone who comes in complaint. It has to do with the earrings on this girl who was supposed to be a nurse, for that has been one of the things we have heard more about than we have about any of the good things.

Then I call to your attention another thing that we think offsets that.

It is true that she has the earrings. They were taken off the picture below. But the thing the Committee on Nursing needs to have in mind, and all of us need to have in mind, in view of the fact that nurses are so badly needed, is that in the discussion of this problem of nurses they want it understood that nurses are not medical associates. They are a profession independent, and something of their own.

I want to call to your attention on page 15, "Dental Hygienists and Dental Associates in General," for this reason, that it is typical of this whole problem, that we estimated that there would be, along with the dental profession giving a similar estimation, that dental services in the United States can be increased by 60 per cent through medical associates. I hope you will read that article particularly.

Incidentally, that was corroborated by the Brookings Institution since we made the estimate.

Then back on page 7, Ophthalmic Associates. What is true in a highly mechanical type of medical practice, such as dentistry, is true here, and I am mentioning it now because I shall bring that subject up again in discussion later.

Now one other thing. What I am saying about this can apply to almost all in general.

On the last page we have nothing to offer. That is page 26, Skin Hygienists and Foot Hygienists. Let us have this in mind, that if there are 140,000,000 people in the United States, there are 280,000,000 feet, and if ten per cent of those hurt, there are 2,800,000 feet in the United States that hurt, and the osteopaths and the bureaucrats are looking at those green pastures. If our orthopedic surgeons would only take that into consideration!

One other thing: Let us remember, as far as associates to the dermatologists are concerned, there are practically none, except the few who are trained in the dermatologists' offices. They are being trained, as you see advertised in the telephone book, by the Dermo-Wave University of Beauty Culture.

I call these two things to your attention. Schools need to be developed, and if we don't do it, it will be done otherwise. Thank you.

The Speaker: This report will be referred to the Reference Committee on Special Committees.

The next item on the agenda is the Report of the Special Committee on Revision of Constitution and By-Laws. Dr. T. K. Gruber of Eloise will give the report. Dr. Gruber has done a monumental work this year—a monumental man for the type of work he has been doing.

VIII. Report of Special Committee on Constitution and By-laws

T. K. Gruber, M.D.: Mr. Speaker and Members of the House: These are not throw-away sheets. These are very important in the operation of this Society.

So far as the sum total of the changes in the Constitution and By-laws, they are very few. The general purport is the same. We have tried to take the By-laws out of the Constitution.

As Dr. Barrett said, at the American Medical Association Convention I predicted that in a short time after the new Constitution and By-laws was passed there would be several amendments. I hope there will be very few amendments to the Constitution. The By-laws can be amended very easily. That is why we tried to get everything in the By-laws that can be amended very quickly.

As to the matter of the duties of the President, if we want to add or subtract this morning or this afternoon, if it is in the Constitution it takes a year to do it.

I hope you will look this over carefully. I am only presenting this by title at the present time. It will go to the Reference Committee on Constitution and By-laws and anyone who has any suggestions, I hope they will appear before this Committee, and we will try to present it.

As to the modus operandi, I think Dr. Spalding and Dr. DeTar have the matter pretty well in hand. We have all read Robert's Rules of Order on how to do the thing, and I hope it will go through rapidly.

It will require the reading of this document to you people, and that will take time. I hope you will be patient, and I hope that if you have any suggestions, you will appear before this Reference Committee while it is convening in Parlor I. Please, if you don't appear there, don't come on the floor and discuss the crossing of a "t" or the dotting of an "i" for two or three hours, because it is going to take two or three hours to do that.

The Speaker: This report will be referred to the Reference Committee on Constitution and By-laws.

IX. Resolutions & Motions

The next item on the agenda, gentlemen, is resolutions. I should like to ask that all delegates who have any resolutions to put before the House of Delegates please come forward and sit in the chairs in the front row.

Are there any resolutions to be presented to the House?

IX—a. VETERANS ADMINISTRATION AT ANN ARBOR

E. D. Spalding, M.D. (Wayne): This is the resolution referred to by your President in his Presidential Address. It has to do with the veterans' hospitals which are springing up like mushrooms throughout the country, and particularly with one that is contemplated near Ann Arbor.

"Whereas, The Veterans Administration proposes to establish and operate a five hundred bed general hospital near Ann Arbor in conjunction with the Medical School of the University of Michigan, and

"Whereas, This proposal is part of an over-all plan of the Veterans Administration to establish throughout the United States for veterans' care hospital facilities to a total of 300,000 hospital beds, and

"Whereas, The number of hospital beds, approximately 118,000, now available for veterans' care is far in excess of any present or reasonably anticipated future needs for care of service-connected disability, and

"Whereas, A great majority of the persons now occupying Veterans Administration hospital beds have no service-connected disability or illness whatsoever, and

"Whereas, The present facilities of the University Hospital at Ann Arbor are adequate for teaching purposes, as well as for the care of indigents referred there under state law. Therefore, be it

"Resolved, That the Veterans Administration should provide veterans with the best of medical and hospital care in all cases of service-connected disability, and with the ultimate in hospital accommodations and equipment necessary to facilitate such care, and be it further

"Resolved, That medical or hospital care in other than service-connected disabilities should be furnished our citizens at government expense on the basis of economic need only, and without reference to service with the armed forces, and be it further

"Resolved, That based on these principles, the num-

ber of hospital beds in Veterans Administration hospitals should be limited to the number required to care for service-connected disabilities only, and be it further

"RESOLVED, That to establish a Veterans Administration General Hospital near Ann Arbor at this time is not necessary and not in the best interest of the public, and be it further

"RESOLVED, That a copy of these resolutions be sent to the Regents of the University of Michigan, to the Dean of the University of Michigan Medical School, to the Dean of Wayne University College of Medicine, and to its governing body, to each State Medical Society, and to the Board of Trustees of the American Medical Association, and be it further

"RESOLVED, That our delegates to the American Medical Association be instructed to present or support similar resolutions to the House of Delegates of the American Medical Association at its next meeting."

THE SPEAKER: The Chair will refer this to the Reference Committee on Resolutions.
Are there any other resolutions?

IX—b. COMPREHENSIVE PRACTICE ACT

C. I. OWEN, M.D. [Wayne]: This is a resolution regarding the Medical Practice Act, presented by myself for the Wayne Delegation.

"WHEREAS, The present laws in the State of Michigan in regard to the healing art approach a state of chaos; and

"WHEREAS, The individual who practices the healing art in one group frequently cannot be distinguished by the public from an individual in another group; and

"WHEREAS, There is inadequate police power for the enforcement of present multiple laws; and

"WHEREAS, There are at least five different groups legally entitled by licensure to practice the healing art in the State; and

"WHEREAS, The present Medical Practice Act is obsolete; and

"WHEREAS, The Special Committee appointed to study the Medical Practice Act has spent considerable time and effort and believes the cause worthy of further time and effort; be it therefore

"RESOLVED, By the House of Delegates that the Michigan State Medical Society through appropriate committee and in co-operation with other members of the healing art duly authorized to practice medicine by licensure do sponsor a comprehensive law which will have for its purpose the regulating and licensing of all phases of the healing art."

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

IX—c. CONSULTATION OF DOCTORS OF MEDICINE WITH OSTEOPATHS

D. B. WILEY, M.D. [Macomb]: I have been instructed by the Macomb County Medical Society to present the following resolution:

"WHEREAS, Certain members of the Macomb County Medical Society have been asked to examine patients in consultation in the Mount Clemens General Hospital, an Osteopathic Hospital, and

"WHEREAS, Frequently, in cases of emergency, patients of Doctors of Medicine have been taken to the Mount Clemens General Hospital, and

"WHEREAS, The number of Osteopaths in Macomb County is more than half the number of Doctors of Medicine, and

"WHEREAS, It is probable that similar situations have occurred, or will occur, in other parts of the state, be it therefore

"RESOLVED, That the Macomb County Medical Society desires to have clarified the status of consultation of Doctors of Medicine with Osteopaths on serious cases, and the question of Doctors of Medicine professionally visiting their patients who have been taken to an Osteopathic Hospital as an emergency case, when their condition is such that transfer to another hospital is not advisable."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.
The next resolution.

IX—d. SPECIAL ASSESSMENT ($25.00)

J. J. LIGHTBODY, M.D., [Wayne]: Mr. Chairman and Delegates: This has to do with a little item called the twenty-five dollar assessment.

"WHEREAS, The need of additional funds for various purposes in the work of the Michigan State Medical Society is apparent; and

"WHEREAS, This need is not static but varies from year to year; and

"WHEREAS, An increase in dues will be of a more permanent nature while a special assessment must be voted each year according to the specific needs; therefore, be it

"RESOLVED, That instead of a raise in the dues of the State Medical Society that the special assessment of $25.00 be continued for the current year."

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of The Council, since it conflicts with some recommendations in the report of The Council.

IX—e. RESOLUTION OF SECTION ON OPHTHALMOLOGY

E. D. KING, M.D. [Wayne]: Mr. Speaker and Delegates: I wish to present a resolution for the Section of Ophthalmology of Wayne County of the Michigan State Medical Society. The draft of this resolution is such that it becomes necessary to present a considerable amount of information, and in order to save time, it has been multigraphed so you may read the same and study it.

THE SPEAKER: Will you present the resolution?
E. D. KING, M.D. [Wayne]:

RESOLUTION FROM SPECIAL COMMITTEE OF THE SECTION OF OPHTHALMOLOGY OF THE MICHIGAN STATE MEDICAL SOCIETY

PREAMBLE

The subject of eye glasses, medical appliances, and drugs, as related to law, ethics, and economics, has reached the stage of a crisis. For several years The Michigan State Medical Society has been studying these problems as they relate to the distribution of medical care, and also to the subject of irregular practitioners in relationship to these problems.

The implications involved are little understood outside of the medical profession. In ethics and economics the case has come to public attention in part through the American Medical Association leadership having dismissed this great problem from analysis by the simple expedient and use of the term "parasites," and the injunction "clean your own house," much in the same way as it left the subject of prepayment medical care and other health problems to others. This publicity has in turn inflamed into action "Better Business Bureau Managers" in two states, certain magazines, and some newspapers, resulting in most unwarranted, harmful and misunderstood publicity.

In law the case comes to public attention by reason of the Federal Government bringing suit under the Sherman Antitrust Act against certain optical companies, contending that these companies have created among themselves a monopoly in restraint of trade.

The two main elements of monopoly are restriction of trade and control of the market. An inseparable incident of any monopoly is the raising of the price of the product.

A certain large optical company is said to have, through agreements with other manufacturers of frames and

mountings, through licenses granted to them under certain patents which it controls, and through threats of ruinous competition, to have forced these firms to adhere to common prices on both patented and unpatented goods, to execute uniform resale price maintenance contracts, and to refuse discounts to distributors who were not on its approved list. It is charged that by these and other means, identical prices have been established and maintained throughout the trade.

This problem has been difficult for the Department of Justice to handle, as when in 1940 under the Sherman Antitrust Act, the Federal Government, through criminal proceedings, lost its case against the large optical companies on the grounds of price-fixing and collusion in restraint of trade. Having lost its case on the first count, the Department of Justice now seeks every possible accessory to monopoly in the case, including so-called "Class Defendants," which defined means in this instance ophthalmologists, most of whom in the United States have accepted so-called "rebates." Rebates are being considered as a possible accessory to price-fixing.

Ophthalmologists are unreservedly for the Department of Justice in its efforts in any field to prevent collusion in restraint of trade, and specifically as against the large optical companies if they are in collusion in restraint of trade. However, the ophthalmologists are being "headlined" as responsible for the high costs of optical goods and for collusion with the optical companies. The facts are that these doctors of medicine prescribe only about 15 per cent of eye glasses; optometrists selling approximately 85 per cent.

The commercial combination of the large optical companies and these optometrists with millions of dollars at their disposal for any advertising and propaganda necessary conducive to the greatest possible profits, has placed the ophthalmologists (doctors of medicine who do not advertise) in a minority position in looking to the best eye-health interests of the people. Basic prices of glasses are regulated by the large optical companies; ophthalmologists are not owners or responsible in any way for the management of these companies that keep the prices up.

Ophthalmologists are the only responsible medium between the optical companies and their patients, and have been and should remain in position to keep prices consistent with the patient's ability to pay.

For fifty years in Michigan and other localities, 99 per cent of the ophthalmologists have thus, by making a retail profit on glasses, or accepting so-called "rebates," been able to charge less for examinations, and, where indicated, see to it also that the cost of glasses was lessened to the patients. This is borne out by the higher examination fees charged by those who have not taken a retail profit on glasses. This is especially the case in many eastern cities where the patients are sent out into the open market for glasses. The high fees charged in such localities together with the high cost of glasses, creates an economic condition that in many cases drives the people to the free clinics and to others than ophthalmologists.

In that realm of medical symptomology represented by such symptoms as poor vision, headache, eye ache, swollen eyelids, redness, tearing, dizziness, double vision, and sensitivity to light, the people seek out a "doctor," or someone who has the word "doctor" in front of his name. An estimated 85 per cent of the patients are first attracted by the advertising of optometrists called "doctors," and commercial employers of optometrists.

Optometrists are licensed to do refractions, which means testing the eyes for visual acuity, finding out which ophthalmic lenses improve the vision most, if any, and selling glasses to the patient.

A refraction is but a small part of a comprehensive eye examination as done by the ophthalmologist. An ophthalmological examination may reveal evidence of health significance ranging from symptoms correctable by glasses, through a long category of symptoms and disease, a few only of which range from impending blindness, systemic disease and brain lesions, to even danger to life itself.

One example of evidence revealed not by refraction, but by a comprehensive examination, is represented in glaucoma, an insidious disease that creeps up slowly, reducing vision to total blindness if not early detected. Of the 250,000 totally blind in the United States, 30,000 are totally blind in both eyes from glaucoma, and another 150,000 are blind in one eye from glaucoma and known to be under treatment for it in the other eye.

As stated, approximately 85 per cent of patients with eye trouble start their eye care through the optometrists in the advertising store, basement store, mail-order house, jewelry store, and some higher grade office building offices, which facts are wholly minimized or ignored by the powerful propaganda advertising of the large optical companies.

A survey of 2,000 cases in one of our large typical cities revealed that the eye-care service including glasses given by optometrists cost an average of $1.92 more than examination and glasses from ophthalmologists. Already, the cheapest optical supply sources are advertising for the doctors' prescriptions.

Seventy-five per cent of the average ophthalmologist's (M.D.'s) practice requires glasses for relief of symptoms in addition to, or in combination with, medical, surgical, or other therapy. Glasses are a piece of merchandise for which the ophthalmologist is responsible to the patient until such time as the patient is relieved of symptoms if he can be so relieved. These glasses may have to be replaced often at the doctor's expense by reason of physical change in patient, and requires service.

To say that a doctor can make his examination, give the prescription, release his responsibility, and turn the patient over to any concern that calls itself a dispensing optical company, or to believe that the patients will go only where directed, in the presence of commercial competition and advertising, as assumed in Better Business Bureau publicity, is unrealistic propaganda, and conceived in ignorance of the doctor's responsibilities.

The quality of ophthalmic products is as varied as that turned out by skilled workmen in high grade optical companies from finest materials, to the cheap magnifying glasses obtainable at many stores.

It is unlikely that retail profits on glasses will be eliminated any more than on any other commodity in America. A retail profit will properly go to someone. If the price of glasses does not fall below a retail level, and if the ophthalmologists' charges have to go up, the cost of glasses alone will be practically the same to his patients as now, and the total cost to the patient will be more and without the ophthalmologist's protection of the patient.

The answer in this economic problem of eyeglasses is not so superficial as just to eliminate so-called "rebates" (which will be done by the ophthalmologists).

For years some ophthalmologists have carried on experiments in the problem of increased distribution of eye care at lower costs by other means than by retail profits through so-called "rebates." Four years ago this activity, along with Medical Associate problems in all health care, reached the point that this House of Delegates set up The Commission on Health Care to bring in reports and recommendations on procedure. This Commission presents at this meeting of the House of Delegates a brochure describing examples of much that relates to the modern evolution of all medical practice, including the subject of Ophthalmic Associates, which is a basic part of the solution to this whole problem.

To remove the retail profit from this aspect of medical care would be an injustice to the younger ophthalmologists especially. Fewer of his patients can pay adequate fees, and he has to be responsible. There is already difficulty in getting enough young men to specialize in ophthalmology, and there are now 5⅔ optometrists to every one ophthalmologist. It would also be an injustice to charge higher fees to patients who do not require glasses.

The probable outcome of the present Antitrust suits will be a consent decree, resulting in an injunction by the government against the system of so-called "rebating." The Sherman Antitrust Act is not aimed at regulating prices, but to allow for freedom of competition. The government is not opposed to doctors of medicine making retail profits; they are only condemning the practice of so-called "rebates." In monopoly it is the size of large companies and collusion between companies that are the concern of the Antitrust Division; size meaning concentrated financial strength sufficient to set prices. No monopoly case has yet been concerned with the amount of profit made, elimination of price-fixing which restricts competition being the end sought.

RESOLUTION

"WHEREAS, we propose if possible to conduct the practice of medicine according to the experience and judgment of a responsible medical profession, working from the scientific, sociological, and economic angles according to plans based on experience, to increase the distribution of good care, and to do so without the coercion of power-ambitious outside interests, or name-calling,

"WHEREAS, the Michigan State Medical Society is in the habit of looking at its problems squarely, fearlessly, honestly, and by analysis, and

"WHEREAS, after analysis, to approach new methods as scientific men should, by planning and experimentation, knowing that the complicated subject of economics in any segment of medicine cannot suddenly be put right safely by any single formula or law,

"WHEREAS, it is out-moded ethics to speak of the practice of medicine as a profession separated from problems of finance,

"WHEREAS, the medical profession *is* in business, having led in voluntary prepayment medical insurance plans, which are big business today and in the best health interests of the people,

"WHEREAS, a highly publicized ruling by a County Society outlawing, in the name of ethics, the handling of any therapeutic product whatsoever upon which the Doctor of Medicine makes any profit toward his compensation, has just come to attention,

"WHEREAS, the cost of drugs and appliances that very many patients need is far beyond what they can pay for at regular rates, as witness for example the cost of vitamins today,

"WHEREAS, in spite of some even medical opinion to the contrary, we believe it will be the consensus of opinion of this House of Delegates that the membership of the Michigan State Medical Society and of the medical profession in general, is as honest and as much to be trusted in all of its responsibilities as any other group of citizens,

"BE IT THEREFORE RESOLVED:

"THAT, it is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"THAT we urge that the ophthalmologists keep within their management the supervision of optical problems, and accept the responsibility involved in the merchandising of glasses to their patients,

"THAT medical associates is one answer to this problem, including medically controlled dispensing offices,

"THAT physicians should be in position to see to it that their patients can have such therapeutic drugs and appliances as are needed at a price they can pay, even if the Doctor of Medicine has to buy at wholesale in order to regulate the price to his patients' circumstances, as he traditionally regulates his fee,

"THAT the Michigan State Medical Society will cooperate fully with the Federal Government as relating to the Sherman Antitrust Act as bearing on the subject at hand,

"THAT the subject of eye care or any other economic problem of medicine is not susceptible to treatment by any decree of the Better Business Bureau or any other agency, wherein the basic understanding of the subject far transcends problems of business,

"THAT we deplore the type of editorials published by the AMA on the subject at hand, giving evidence of no comprehensive study and understanding of the subject,

"THAT the American Medical Association, and Better Business Bureau, and the newspapers be advised that the Michigan State Medical Society is much concerned that the cost of all therapeutic drugs and appliances be lowered as much as possible consistent with good quality, scientific accuracy, good service, medical supervision, and well trained and well paid workmen who are responsible to the Doctor of Medicine, who is in turn responsible to the patients for results, and

"THAT copies of this Resolution be transmitted to the Better Business Bureau of Detroit, the American Medical Association, and the press."

THE SPEAKER: This resolution is referred to Special Reference Committee on Ethics.

THE SPEAKER: Are there other resolutions?

IX—f. CREATION OF 17th & 18th COUNCILOR DISTRICTS

W. W. BABCOCK, M.D. [Wayne]: This resolution is presented by the Wayne County Medical Society in the form of a petition to the House of Delegates:

"Under the present organization of the Councilor Districts in the Michigan State Medical Society, Wayne County with 43 delegates out of the total of 118 (or 36 per cent of delegates) comprises the First and Sixteenth Districts, and therefore has only two Councilors out of the total of sixteen (or 12½ per cent of the Councilors). Therefore, the Wayne County Medical Society hereby petitions the House of Delegates of the Michigan State Medical Society to subdivide the present First District into the First and Seventeenth, and the present Sixteenth District into the Sixteenth and Eighteenth, each with a Councilor of its own. This will make a total of four Councilors for Wayne County out of a new total of 18 (or 22.2 per cent of Councilors), representing 36 per cent of the delegates."

THE SPEAKER: This resolution will be referred to the Reference Committee on Constitution and By-Laws, since that question is coming up in their meeting this afternoon.

Are there any other resolutions?

IX—g. PROPOSED REDUCTIONS IN TERM OF COUNCILORS

ARCH WALLS, M.D. [Wayne]: This is a resolution in regard to the Councilorship term.

"WHEREAS, The Councilorship in the Michigan State Medical Society is now five years and continued reëlection possible; and

"WHEREAS, A longer term of service may make an undue demand on members who have served their local societies long and well; therefore, be it

"RESOLVED, That the By-laws be amended so that a councilorship be of three years' duration rather than five and no councilor may succeed himself but once."

THE SPEAKER: This resolution will be referred to the Reference Committee on Constitution and By-laws.

IX—h. CREATION OF MEDICAL LIBRARY SERVICE

E. G. KRIEG (Wayne): This resolution is to make literature available throughout the state to those who have difficulty in obtaining it.

"WHEREAS, Medical science has become so extensive and is constantly and rapidly advancing in old and newer fields; and

"WHEREAS, The record of this knowledge is published and disseminated through numerous scientific publications; and

"WHEREAS, Access to this material cannot be readily obtained by physicians who practice at some distance from the larger urban or medical centers; and

"WHEREAS, Prompt utilization of the newer scientific discoveries bears a direct relationship to the general health and well being of the people of our State, therefore, be it

"RESOLVED, That this House of Delegates instruct the Committee on Postgraduate Teaching or other suit-

able committee to meet with the State Library Commission at an early opportunity with the purpose in mind of establishing a medical library service similar to that now operating in the State of Iowa."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

IX—i. TOKEN OF ESTEEM TO E. R. WITWER, M.D., DETROIT

DOUGLAS DONALD, M.D. (Wayne): Mr. Speaker, this resolution is presented by the Wayne Delegation.

"WHEREAS, Eldwin R. Witwer, M.D., has been a member of The Council of the Michigan State Medical Society representing the 16th District for six years, and Delegate for over twenty years time; and

"WHEREAS, His services have been of such outstanding quality, he having served truly, honestly, justly and without stint or thought of himself, and

"WHEREAS, The Council and the Michigan State Medical Society and his colleagues have benefited richly by his wise, fair and cheerful counsel, and

"WHEREAS, He has found it necessary to regretfully resign his office on the Council for true, valid and necessary reasons; therefore, be it

"RESOLVED, That the Michigan State Medical Society, through its House of Delegates and the Council, herewith tender to ELDWIN R. WITWER, M.D., its regrets that circumstances have induced him to do so; and be it further

"RESOLVED, That it present him with an illuminated and decorative parchment scroll as a small token of its esteem and appreciation as well as its friendship for the many hours of labor, wisdom and energy he has given so willingly, and be it further

"RESOLVED, That the scroll shall read:

> " 'This Scroll is presented to Eldwin R. Witwer, M.D., by the Michigan State Medical Society, its House of Delegates and The Council, in recognition of his long and faithful service, cheerfully, energetically and wisely performed, with keen and deep appreciation for the efforts and sacrifices he has made to further the ideals, principles and tenets of Medicine, and the Michigan State Medical Society and to benefit his colleagues and friends.
>
> " 'Presented this twenty-third day of September in the year of Our Lord nineteen hundred and forty-eight.'

and be it further

"RESOLVED, That a copy of this resolution shall be placed on the pages of the minutes of the Michigan State Medical Society transactions and a copy thereof appear in the Journal of the Michigan State Medical Society."

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of The Council, since Dr. Witwer has been a Councilor of long standing in the Society.

IX—j. CREATION OF COMMITTEE ON GERIATRICS

H. H. RIECKER (Washtenaw): Mr. Speaker and Members of the House of Delegates:

"The problem of the general care of the elderly citizen in the State has become difficult in recent years because of the increased longevity of the population, industrialization attended by concentration of the people in urban centers with a decreased proportion of the rural population, the scattering of family groups, and the inadequacy of housing facilities.

"The problem presents social, economic and medical aspects, of which the latter always are present and may predominate.

"It would be helpful to both the citizens of the State and its physicians, if one stable organization such as the MSMS should assume responsibility for solving this problem or contribute to its solution by a definite and organized effort. At one time or another the problem of the care of the elderly person is presented to every family and every physician in the state. Therefore, be it

"RESOLVED, That the House of Delegates direct the President of the Michigan State Medical Society to appoint forthwith a committee whose duty it shall be:

"(1) To investigate and survey the present facilities for proper and adequate care of the elderly citizen who is in need of it.

"(2) That this be done at the county or district level in co-operation with the county medical societies.

"(3) That the inquiry embrace present facilities for the economically indigent, borderline, as well as the well-to-do.

"(4) That the extent and urgency of the problem be determined in each county together with any measures now being taken contributing importantly to its solution.

"(5) That the Committee suggest, if possible, measures by which the organized profession may assume leadership in a field not now adequately served by any other agency.

"(6) That the Committee be given adequate financial support for this project (at the discretion of The Council) in order that a full report can be made to the House of Delegates at its next annual meeting." (See page 1279.)

THE SPEAKER: This resolution will be referred to the Reference Committee on Special Committees, since it involves the appointment of a special committee.

IX—k. RECOGNITION OF 46 YEARS ATTENDANCE BY A. V. WENGER, M.D. GRAND RAPIDS

R. S. BREAKERY, M.D. (Ingham):

"WHEREAS, A. V. Wenger, M.D., has established record of unbroken attendance at the meeting of the Michigan State Medical Society since 1902, a period of 46 years, and

"WHEREAS, Doctor Wenger has served the State Society as a Delegate of Kent County continuously from 1917 to date, a period of 31 years, and

"WHEREAS, Over this period his effort has been without recompense, therefore, be it

"RESOLVED, That this House formally recognize such unselfish and understanding effort in behalf of medicine and the physicians of Michigan by hereby expressing its gratitude to Doctor Wenger and further be it

"RESOLVED, That the Secretary be instructed to advise Dr. Wenger of this action and that the publication of this record be made in the Journal of the Society in a prominent position."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Incidentally, before the next resolution comes up, all resolutions on special memberships will not be read at this session. They should simply be handed to Dr. Foster. He will send them in a body to the Reference Committee on Special Memberships."

IX—l. REQUISITES FOR NURSE TRAINING

E. J. ROBSON, M.D. (Ingham):

"WHEREAS, There has been an increasing shortage of available registered nurses for the staffing of hospitals, and for private duty either in hospitals or homes; and

"WHEREAS, this shortage has been acutely felt throughout the entire country, to the extent that even governmental agencies have endeavored to increase the number of students in nurses' training schools; and

"WHEREAS, at a recent national meeting it was proposed that training schools for registered nurses be limited to larger teaching or university hospitals, thus greatly diminishing the present number of training schools for registered nurses; and

"WHEREAS, as proposed, student nurses in smaller or non-teaching hospitals would be trained only as 'practical nurses,' with a two-year course to supplant registered nurse trainees or graduates, thereby lowering the standards of training below that now required in nurses' training schools; and

"WHEREAS, the proposed increased pre-nursing school requirements will without doubt result in fewer applicants for such training; therefore, be it

"RESOLVED, that through its House of Delegates, the Michigan State Medical Society deplore and strongly oppose any such step which would reduce the number of trained nursing personnel or substitute an inferior training for the present registered nurses' course of training as currently conducted in all of the hospitals accredited for such courses; and be it further

"RESOLVED, that the program for training nurses aides be continued and encouraged, but not, however, at the expense of the existing training and qualifications for registered nurses, and further be it

"RESOLVED, that any further educational prerequisites for this profession be reserved for that group of nurses who elect to prepare themselves for specialized nursing or for instructorships in schools of nursing, thereby elevating the standards of training in all of the now existing schools for registered nurses, and further improving the caliber of this vital profession."

THE SPEAKER: This resolution will be referred to the Reference Committee on Special Committees, since that committee considers the report of the Committee on Nurses' Training Schools.

Are there any other resolutions?

IX—m. A.C.S. HOSPITAL STANDARDS

W. B. HARM, M.D. (Wayne):

"WHEREAS, The Michigan State Medical Society feels that it is the governing body in the State of Michigan for its own members; and

"WHEREAS, The Michigan State Medical Society through its county and state Ethics Committees has the authority and means of disciplining its members; and

"WHEREAS, the American College of Surgeons through its inspection of hospitals insinuated that some members of the Michigan State Medical Society were guilty of unethical practices without submitting any proof of these deeds; and

"WHEREAS, the American College of Surgeons insisted that hospital superintendents discipline members of their staffs and force their members to sign pledges laid down by the American College of Surgeons for their own members; and

"WHEREAS, the vast majority of the members of the Michigan State Medical Society are not members of the American College of Surgeons and therefore should not be subject to its rules and regulations in any manner; and

"WHEREAS, the American Medical Association has always recognized the county society as the interpreter locally of the Code of Ethics of the American Medical Association, therefore, be it

"RESOLVED, that the Michigan State Medical Society notify the American College of Surgeons that any infractions in ethics by Michigan State Medical Society members with proof of such infractions hereafter be submitted to the Ethics Committee of their county society or of the State Society for discipline rather than to superintendents of hospitals, lay or otherwise; and be it further

"RESOLVED, that the Michigan State Medical Society request the American Medical Association to assume the approval of hospitals for the training of interns and residents and that approval of such hospitals and such training be entirely independent of any approval or disapproval by the American College of Surgeons or any other specialized organization."

THE SPEAKER: This resolution will be referred to the Reference Committee on Ethics, because it involves the identical problem which has already been referred to them.

IX—n. FORMATION OF NATIONAL AGENCY FOR VOLUNTARY HEALTH SERVICE PLANS

R. H. BAKER, M.D. (Oakland): Speaking in behalf of the Oakland Delegation, I present this resolution.

"WHEREAS, there are continuing demands for National Health Insurance by one of the major political parties of our country, and a modified form of the same has already been urged by powerful elements in the other major political party, so we must conclude that the danger of some such legislation being passed by Congress is very real, and

"WHEREAS, the doctors of the State of Michigan believe that a successful voluntary prepayment plan for medical care is a most constructive effort to improve human relations and safeguard the public health in a democratic manner, and

"WHEREAS, the doctors are fully aware that to oppose compulsory health insurance by voluntary prepayment plans, these plans must be available and enthusiastically supported by all the states in a unified effort (which is far from the fact) and that this effort can only be made at the national level, and

"WHEREAS, the seventy-odd Medical Care plans listed by the Council on Medical Service of the AMA represent worthy efforts in certain parts of the country, at the city, county and state level, yet as a whole they lack strength because their individual fields are too narrow and, lacking co-ordination, they do not meet the National need, and

"WHEREAS, Dr. Paul R. Hawley, head of the Blue Shield and Blue Cross Commission, a man whose driving energy in both war and peace has been proven, and who now has suggested a National Service Agency for securing a co-ordination of effort and uniformity of detail in these seventy-odd plans which will serve to greatly strengthen their position and reasonably answer some of the criticism directed against the voluntary insurance system, therefore, be it

"RESOLVED, that this House of Delegates of the Michigan State Medical Society instruct the Board of Directors of Michigan Medical Service to encourage and proceed to the formation of a National Agency for Voluntary Health Service Plans, and be it further

"RESOLVED, that the Michigan Delegates to the American Medical Association be instructed to present a resolution to the House of Delegates of that Association, urging the AMA to exert its support and encouragement to extend Voluntary Health Service Plans in areas not now served and the inclusion of such plans into a National Agency, and

"RESOLVED, Further that a copy of this resolution be sent to the Council on Medical Service of the AMA and to the Associated Medical Care Plans." (See page 1282 for two amendments adopted by House of Delegates.)

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Are there any other resolutions to come before the House?

There will be another opportunity to present resolutions at the meeting tonight and at the meeting tomorrow. None can be presented, without the unanimous consent of the House, on Tuesday evening.

If there are no more resolutions, we will proceed with the agenda for a few minutes before lunch.

The Chair will ask if there are any reports of the Standing Committees. I will ask you to take your Handbooks and refer to page 63. The reports of the Standing Committees are listed from page 63 on. The Chair will call for any additional reports which may be forthcoming at this time.

X. Reports of Standing Committees

X—a. THE LEGISLATIVE COMMITTEE

X—b. THE COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

X—c. THE MEDICAL LEGAL COMMITTEE

X—d. THE PREVENTIVE MEDICINE COMMITTEE (X-d includes X-e through X-m)

X—e. COMMITTEE ON CANCER

X—f. MATERNAL CARE

X—g. VENEREAL DISEASE CONTROL

X—h. TUBERCULOSIS CONTROL

X—i. INDUSTRIAL HEALTH

X—j. MENTAL HYGIENE

X—k. CHILD WELFARE

X—l. IODIZED SALT

X—m. HEART AND DEGENERATIVE DISEASES

Are there any additional reports from

X—n. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

X—o. COMMITTEE ON ETHICS

If there are no additional reports from the Standing Committees, the Chair will refer the reports as published in the Handbook to the Reference Committee on Standing Committees.

X—p. PUBLIC RELATIONS COMMITTEE

L. W. Hull, M.D. (Wayne): Mr. Speaker?

The Speaker: Dr. Hull, Chairman of the Public Relations Committee. Do you care to give your report?

L. W. Hull, M.D.: Yes. I understand this extra report can only be given now.

The Speaker: All right. Dr. Hull will give the report of the Committee on Public Relations.

L. W. Hull, M.D.: Mr. Speaker and Members of the House of Delegates: This is a supplemental report of the Public Relations Committee.

SUPPLEMENTAL REPORT OF THE PUBLIC RELATIONS COMMITTEE

In view of the fact that the report published in the House of Delegates Handbook was prepared some three months ago, and in the meantime some outstanding progress has been made, it was felt by the Public Relations Committee that a supplemental report should be given. I offer the following:

1. *Radio:* The "Tell Me, Doctor" radio program is now being carried daily by 23 Michigan radio stations. In addition, it is being heard over 12 stations in Virginia, 20 in Oklahoma, 1 in West Virginia, and several in South Carolina, making a total of over 60 stations broadcasting this program. In view of these facts and the fact that no station which has ever accepted the program has ever dropped it for any reason, I think it can truly be said that this quiet persistent and interesting daily radio program is the outstanding medical radio broadcast in the United States today.

There have been triumphs in other fields of which we are proud. Even to review them would be tedious and yet their value is enormous. The salutary effects of the Michigan Rural Health Conference as a single example, would require much time to develop fully. However, we do wish to offer an example of a new media which has been developed in the MSMS Public Relations program this year and I would like to yield to Dr. Walls to present this project.

Arch Walls, M.D. (Wayne): A year ago I came before the House of Delegates with a very red face, in presenting the Report on Cinema. Today I hope my face will be bleached out.

We have worked this year in completing this cinema, which will be shown in four modern theaters throughout the State of Michigan in the next three months. It was shown last night in the Fox Theater and received a very fine reception.

After it is shown here, we expect to be able to sell this and rent it to other states and other organizations. We will be ready to show this and it will take ten minutes.

It is my pleasure to present the cinema, with your approval.

(Showing of MSMS Motion Picture, "Lucky Junior")

The Speaker: This picture was shown as part of the report of the Public Relations Committee.

Is there any additional supplemental report from the Public Relations Committee, Dr. Hull?

L. W. Hull, M.D. (Wayne): There is nothing else.

The Speaker: Then the reports of the Standing Committees, including this committee, will be referred to the Reference Committee on Standing Committees.

XI. Reports of Special Committees

We have ten minutes more. I would like to go through the next item of the agenda, which is the reports of special committees, and ask if there are any supplemental reports, if you will turn to page 95. After all, it is our duty to criticize these reports to the Reference Committee if we have any different opinions about them.

Are there any supplemental reports or special reports from:

XI—a. COMMITTEE ON NURSES' TRAINING SCHOOLS

XI—b. COMMITTEE ON SCIENTIFIC RADIO

XI—c. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

XI—d. SCIENTIFIC WORK COMMITTEE

XI—e. BEAUMONT MEMORIAL COMMITTEE

XI—f. THE STATE INTERPROFESSIONAL COMMITTEE

XI—g. RHEUMATIC FEVER CONTROL COMMITTEE

XI—h. COMMITTEE ON STATE VETERANS AFFAIRS

XI—i. COMMITTEE ON UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

XI—j. COMMITTEE ON RURAL HEALTH

XI—k. COMMITTEE ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND

XI—l. COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

If there are no reports from any of the committees named, the Chair will refer the reports as published in the Handbook to the Reference Committee on Special Committees.

The Chair would like to ask Dr. Morrish how long the report for his committee will take.

R. S. Morrish, M.D. (Genesee): Mr. Chairman, not more than ten minutes.

XI—m. RED CROSS BLOOD BANK COMMITTEE

The Speaker: The Chair would like Dr. Morrish to come to the platform and report for the *Red Cross Blood Bank Committee.* That is a special committee.

R. S. Morrish, M.D.: Mr. Speaker and Members of the House: On page 170 of the Handbook for Delegates there is a report of the Committee on the Red Cross Blood Bank program, and as a supplemental report I wish to give you and the members of the House the opportunity to listen to some first-hand information on the present status of the National Blood Bank Program from one of the National Staff.

I recommend that the speaker recognize Dr. Raymond F. Barnes, Medical Director of Health Services of the Midwestern Area for the American Red Cross.

Mr. Speaker, I so recommend.

The Speaker: Dr. Barnes. The Chair is very glad to introduce Dr. Barnes, who will talk on the Red Cross Blood Bank, as part of the supplemental report of Dr. Morrish's Committee.

Dr. Barnes!

Raymond F. Barnes, M.D.: Mr. Chairman and Members of the House: I know you are tired. You have been here a long time, and I am going to be just as brief as I possibly can.

I am here to give you, as nearly as I can, the status of this blood program in Michigan. Some activities have taken place, and we believe you should have all the information about that—the past, the present, and the plans for the future—first-hand, rather than to get it second-hand and get it in some cases wrong, from which misunderstandings and mistrust and strained relations often develop.

I would like to give about one or two or three of the fundamental policies of this program to you, because I think they are important in your thinking, and then to go to the situation in Lansing and Detroit and possibly Muskegon.

In the first place, we have thrown this term "national" around quite a bit because it is handy. I think it has been a mistake. This plan is not designed to be a nationally directed program from Washington. It is designed to be national in scope, a series of individual, autonomous, community blood programs, which represent a partnership between the local medical societies and the local citizens, comprising the Red Cross Chapters. It is really that simple.

The only thing coming from National Headquarters will be the money to supply the laboratory in which this blood may be taken care of and a technical manual—suggested, not imposed on the local medical group. It is gotten out by thirty-five of our special men in the country.

In no county will a program be initiated by the Red Cross without the prior approval and co-operation of the Medical Society of that county. I think that is the best way to keep it absolutely safe.

When that County Medical Society does agree to a program locally, then they are given complete technical control. The medical director of that center, who has charge of all technical alterations, is appointed by the local county medical society. He is backed up and guided by a medical advisory committee, again appointed by the medical society. He can do anything with that technical apparatus, with that technical program, the mobile unit operations and all, provided he is backed up by his medical advisory committee from his medical society.

One other thing, and then Lansing. This program takes in some of the outlying counties around each regional center. There again each medical society has to approve before the thing occurs in the program. The medical society, when they do agree to come into the regional program, appoint a medical man to represent them with the medical group in this center chapter, center county, and again each county is tied in definitely with the setup.

The Red Cross merely gets the donors in, furnishes the location, furnishes the equipment and publicity, and volunteers to get the donors in, to the end that blood will be available in every hospital for the physician's use, and he is free to charge what he pleases for administration. There is no interference in doctor-patient relationship.

Now, Lansing. About eight or nine months ago—I am not sure just how long—I met with your State Medical Society Blood Committee—Dr. Morrish, Dr. Cooksey and Mr. Burns were there—helping to discuss it, and I met later with the Ingham County Medical Society and discussed it with them. They approved it. It has been some time. Things have been a little slow there because space in buildings is hard to find. There is scarcely a building. But now a building has been secured which will house the volunteer center to get blood for Ingham County, but it will not be sufficiently large to house the laboratory, so for a temporary period the laboratory space will be given in the State Laboratories at the State Health Department, in which this processing can be done until larger quarters are found.

The Ingham County Medical Society has chosen a medical director—Dr. G. D. Cummings, whom most of you know, I am sure. He is in charge of the State Laboratories and is active in medical circles there. The quarters have been obtained and all personnel have been obtained through the Medical Society, through Dr. Cummings, local people when possible, nurses and technicians, and they have contemplated opening that center to supply that county and those surrounding counties that are ready about October 15. I personally believe they will fall a little beyond that, because I doubt whether they will be ready. Each county medical society has to be contacted. I can't name you the counties because it depends entirely upon the approval of the medical society in each of those counties.

That is the situation in Lansing, as nearly as I can give it to you up to date.

In Detroit a local program has been in progress for some time, with the approval of the Wayne County Medical Society. It has not been able to supply all the needs of Detroit because they are too great for just that one center, getting nothing from the outlying communities. Certain of the hospitals had their banks and did not want to give them up, which was perfectly proper and right.

The Detroit Chapter had wanted to get a regional type center. We have had to say "no" because the Medical Society of Wayne County has not yet approved of that type of center.

I am to meet with them this afternoon. I understand they have some mutual understanding with the Wayne Medical Society. I don't know. I can tell you more about that in a day or two.

Muskegon is running a county-wide society for its own use. That is all for the present.

Contemplated in the future perhaps is Marquette, where apparently blood is pretty badly needed.

Those are the only plans we have in Michigan at this time. I may say that our Board of Governors is meeting this week, and I believe they are going to finish up those centers that are planned, in which the medical society wants them, for this fiscal year, and then take a breathing spell for about a year and watch them perfect them. We have made mistakes. We are going to make some more. In pioneering you will do that. We are going to perfect them, and that should be all for Michigan for perhaps another year.

I think that is the status of things here. I don't believe I have left out anything. Thank you very much.

THE SPEAKER: Thank you, Dr. Barnes.

Are there any other supplemental reports of any of the special committees?

If not, all reports of these committees will be referred to the Reference Committee on Reports of Special Committees.

Gentlemen, before we recess, I should like to ask, is Dr. Dibble in the room?

Dr. Dibble, are the members of the press with us?

H. F. DIBBLE, M.D. (Wayne): There are one or two. I don't know whether they are all here.

THE SPEAKER: I should like to have you express the desire of the Speaker, if it is agreeable to the rest of the House, that we should be very glad to have the members of the press sit in on our deliberations. We encourage the co-operation of the press. We are very glad to work with the press. I wish, Dr. Dibble, that you, as chairman of the Press Committee, would ask the members of the press to clear all information with your committee after each session, before publishing it.

I should like to ask Dr. Novy if he has anything special to say to us in regard to the meeting of the Michigan Medical Service.

R. L. NOVY, M.D. (Wayne): As soon as I get through, they will begin bringing in refreshments, and everybody in the room, delegates or otherwise, is invited to be present. We hope to start the Michigan Medical Service meeting this afternoon at 2:30. As you know, everybody in this body is a member of the Michigan Service Corporation, if you call it that, and it is your duty to see that proper men are elected to carry our your wishes in regard to that service. So we will start serving immediately.

Another thing. Michigan Medical Service is maintaining a headquarters for delegates in Room 681, which will be open after four o'clock this afternoon and throughout the convention meeting, and we would like to have you come up here at any time and accept our hospitality. Thank you.

THE SPEAKER: Gentlemen, before recessing, the Chairman of the Reference Committees are asked to come to the platform to receive the resolutions which were referred to their committees.

Now immediately at the close of this meeting—that is, right now, for the next fifteen minutes—the Chairman of the Reference Committees would like to see their committees in the rooms which are stipulated in your Handbook.

The Special Reference Committee on Ethics will meet in Room 1019.

These are only for fifteen minutes, enough for you to get your committees organized.

The Reference Committees will reconvene at 4:00 p.m. I should like to say that any member of the House of Delegates who cares to appear before any of the Reference Committees to support or to disagree with any of the resolutions which have been presented should be in the Reference Committee Rooms stipulated in the Handbook at four o'clock.

Gentlemen, I feel there is some idea on the part of the Michigan State Medical Society members that the House of Delegates and the Reference Committees are simply rubber stamps of the officers' reports and the committee work. This should not be. The Reference Committees are urged to be critical and constructive.

We will reconvene the session of the House of Delegates at 8:00 p.m. If there is no other business, the meeting is recessed.

(The meeting recessed at 1:20 p.m.)

Second Meeting

MONDAY EVENING

September 20, 1948

The meeting convened at nine-thirty o'clock, J. S. DeTar, M.D., the Speaker, presiding.

THE SPEAKER: The House will please come to order.

May we have the report of the Committee on Credentials, Dr. O'Meara.

J. J. O'MEARA, M.D. (Jackson): Mr. Speaker, I hold the names of 94 members, 40 per cent of which is a quorum, 50 per cent of which is not from any one county.

THE SPEAKER: Thank you, Dr. O'Meara. The Report of the Committee on Credentials will be accepted as a roll call, if there is no objection.

Is there any unfinished business left over from this afternoon? If not, is there any new business?

Are there any additional resolutions?

IX—o. TO INCREASE NUMBER OF MEDICAL GRADUATES

C. J. BARONE, M.D. (Wayne): Mr. Speaker, I have a resolution I would like to present. This is a resolution to attempt to get more doctors graduated from our medical schools.

"WHEREAS, The Ewing report states a 20 per cent shortage of physicians exists for the adequate medical care in the United States, and

"WHEREAS, Officers of the State Society brought this shortage to our attention and stressed the need particularly in rural areas, and

"WHEREAS, The hospital administrators are being hard pressed to obtain sufficient intern and resident staffs, and

"WHEREAS, The insufficient doctors are graduated to replace those that die and retire on account of illness and age, and

"WHEREAS, Insufficient doctors are graduated to adequately care for the increase in population, and

"WHEREAS, The facilities for teaching are the same as when more were graduated during the war, and

"WHEREAS, The present curbing of graduates and/or admission is due to postwar regulations and controls of the American Medical Association, and

"WHEREAS, The number of individuals other than M.D.'s licensed to practice the healing art in the State of Michigan has increased materially, therefore, be it

"RESOLVED, That the Michigan State Medical Society, through its officers, initiate a movement to increase the number of students graduated from the medical schools in this State and that the delegates to the AMA initiate a similar movement on a national basis, to increase the number of physicians graduated and that the delegates to the American Medical Association initiate a movement to establish new medical schools in those states where none now exists."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions, out of deference to the very splendid work that Dr. Bromme and his committee have done. They say they have finished their work, so certainly they should have some more.

Are there any other resolutions?

Is there any other new business to come before the House?

XII. Reports of Reference Committees

If there are no additional resolutions, we will proceed with the next item on the agenda, which is the report of the Reference Committee on Officers' Reports. Is the Chairman of that Committee here?

XII—a. ON OFFICERS' REPORTS

D. R. SMITH, M.D. (Iron Mountain): The Committee on Officers' Reports moves that the *Speaker's Address* be accepted as read. The Committee unanimously commends the Speaker's statements on impractices and the Michigan Health Council. The Committee urges that the delegates co-operate with the State Public Relations Committee and The Council in implementing their recommendations on Impractices and the Health Councils.

Mr. Speaker, I move the adoption of this resolution.

THE SPEAKER: I think we will take this up one by one. This motion is in regard to the items taken up in the Speaker's Address. Did you hear them, gentlemen?

It has been moved that the Speaker's address be approved.

(The motion was seconded.)

Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

D. R. SMITH, M.D.: The Committee recommends that *President P. L. Ledwidge's address* to the House of Delegates be accepted as presented, and that he be commended for his excellent presentation which contains much food for thought, and further, that Dr. Ledwidge be thanked again for his excellent leadership as President during this past year.

Mr. Speaker, I move the adoption of this resolution.

THE SPEAKER: You have heard the motion concerning the President's Address. Is there a second?

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; contrary, "no." The motion is passed.

D. R. SMITH, M.D.: *President-Elect Sladek's Address.* I move that Dr. Sladek's address be accepted as read and that attention be called to the five major points which are of utmost importance:

1. Blue Cross, Blue Shield extension plans
2. Union Health Funds
3. Better Organization and better informed membership in county societies
4. Need for new quarters in Lansing
5. Geriatrics

The Committee recognizes the importance of geriatrics and approves the formation of a Committee on Geriatrics to study this problem. Mr. Speaker, I move the adoption of this resolution.

THE SPEAKER: You have heard the motion. Is there a second?

F. A. WEISER, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion on the motion for approval of Dr. Sladek's suggestions and address? If there is no discussion, all in favor say "aye"; opposed, "no." The motion is passed.

D. R. SMITH, M.D.: The Committee approves the report of Dr. Wyman Barrett for the A.M.A. delegates in the absence of Dr. L. G. Christian. Mr. Speaker, the Committee recommends its adoption.

H. W. WILEY, M.D. (Lansing): Second the motion.

THE SPEAKER: Is there any discussion on the motion that the report of the Delegates to the American Medical Association be approved? If not, all in favor say "aye"; opposed, "no." The motion is passed.

D. R. SMITH, M.D.: Mr. Speaker, I move the adoption of the report of the Reference Committee on Officers' Reports.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

THE SPEAKER: Is there any discussion on the motion that the report of the Committee as a whole be adopted?

I should like to commend the Committee on tearing apart the various items and singling them out, because those things which are singled out will be taken up more in detail by your officers during the ensuing year.

Is there any discussion on the motion? If not, all in favor say "aye"; opposed, "no." Motion passed.

Thank you very much, Dr. Smith.

XII—b. ON REPORTS OF THE COUNCIL

The next item on the agenda is the Report of the Reference Committee on Reports of The Council, Dr. Weston, Chairman.

C. L. WESTON, M.D. (Owosso): Mr. Speaker and Members of the House: Will you please open your Handbooks to page 37. On this page, in the report of The Council on Membership it is the recommendation of the Committee that in the annual report on membership there be recorded the number and location, if possible, by counties of licensed practicing doctors of medicine who do not belong to the State Society. It is recommended, further, that there be a sustained and continuous drive for 100 per cent membership.

Finances. The Committee did not understand, and would like an explanation of the fact that on an investment of $84,600 in bonds there is an income of interest of only $346, when most of the bonds presumably bear 2.5 per cent interest.

We would like a further explanation of the necessity of holding the sum of $100,000 in the Public Education Reserve Fund and also an explanation of why in one place (top of page 38) it is called a reserve for contingency. It is the understanding of the Committee members that this fund was not earmarked for any particular purpose but that it was to be used at the discretion of The Council.

JOURNAL. No comment.

Organization. It is recommended that some provision be made to acquaint the Alternate Delegates as well as the Delegates to the American Medical Association with American Medical Association proceedings, and that the Alternates be permitted to attend the American Medical Association House of Delegates meetings.

Public Relations Program. The Reference Committee

believes that the report is excellent and comprehensive and congratulates all parties concerned.

Committees (page 43). Committee on Scientific Work. No comment. Public Relations Committee. See comment under Public Relations Program. Cancer Control Committee. No comment. Venereal disease program. No comment. Committee on Study of Medical Practice Act. No comment. Advisory Committee to the Woman's Auxiliary. No comment. Committee on Constitution and By-laws. No comment, but there should be plenty of comments when the report is submitted to the House. National Emergency Medical Service Committee. It is recommended by this Reference Committee that the State Committee of the National Emergency Medical Service Committee be commended on its work and that it be urged to carry it on to the county level as rapidly as possible. Rheumatic Fever Control Committee. The Reference Committee compliments this Committee on its excellent work and recommends that it be continued. Committee on Courses in Medical Economics. It is recommended that the work of this Committee be continued and furthered wherever possible.

Permanent Conference Committee with Michigan Hospital Association, Michigan State Nursing Association and Michigan State Pharmaceutical Association. It is recommended that this Committee be continued.

Committee on Postgraduate Medical Education. The Reference Committee compliments President-Elect Sladek on his election as President of the National Organization and Dr. H. H. Cummings on his election as Secretary-Treasurer of the National Organization. It is obvious that the Committee has done outstanding work.

Committee on Dues Structure. No comments at this time. This will be considered under recommendations.

Liaison Committee with Michigan Hospital Association. No comment.

Contacts with Governmental Agencies (Page 46).

(1) Contacts with United States Senators and Congressmen in Washington, D. C. It is recommended by the Reference Committee that contacts with Senators and Congressmen in Washington be continued, and that in so far as possible, the membership of the Society be kept informed concerning them.

(2) Michigan Hospital Licensing Bill. The Reference Committee supports the action of the Special Committee of The Council in voicing their non-approval of the Hospital Licensing Bill as proposed.

(3) Liaison between Michigan Crippled Children Commission and Michigan State Medical Society. The Reference Committee commends the liaison between these two groups, and recommends that it be continued.

(4) Michigan Department of Health. No comment.

(5) Basic Science Act. The Reference Committee believes that there should be clarification of the Medical Practice Act in regard to resident training.

(6) Michigan Department of Public Instruction. No comment.

(7) State Vocational Rehabilitation. The Reference Committee recommends more medical participation in the planning of vocational rehabilitation at all levels.

Contacts with non-governmental agencies. (Page 49).

(1) Michigan Hospital Service—Mercy Hospitals Matters. The Reference Committee acknowledges that the Special Committee of The Council has worked diligently and sincerely on this problem and trusts that the conferences will ultimately be successful.

(2) Michigan Medical Service. The Reference Committee agrees with this statement and would like to emphasize the value of Michigan Medical Service.

(3) Michigan Society for Crippled Children and Adults. This Committee wishes to compliment the Michigan Society for Crippled Children and Adults for its excellent assistance in carrying out the Rheumatic Fever Program.

(4) Michigan Foundation for Medical and Health Education, Inc. No comment at this time. There will be one later under recommendations.

(5) Rural Health Conference. The Committee congratulates the Conference and especially the assistance of the Public Relations Committee in making it successful and recognizes the assistance of Michigan State College. The Committee urges strongly that annual rural health conferences be established.

(6) Michigan Health Council. The Reference Committee approves the ideas which underlie the Michigan Health Council and hopes there will be some tangible evidence of action in the near future.

(7) Michigan Association of Health, Physical Education and Recreation. No comment.

(8) Michigan Parent-Teacher Congress. No comment.

(9) Michigan Hospital Association. No comment.

(10) Michigan State Pharmaceutical Association and State Bar of Michigan. No comment.

(11) American Heart Association. (See fine print on Page 52). The Reference Committee endorses wholeheartedly the statement on Page 52 in fine print.

(12) American Medical Association. The Reference Committee compliments the Michigan Delegates' action in procuring a change of the insurance policy by the American Medical Association. (See also previous comment under "Organization.)

New Projects and Miscellaneous Activities.

(1) Immunization Month. The Reference Committee compliments The Council on its activity in regard to Immunization Month and recommends that Immunization Month be made an annual affair.

(2) Survey of Rural Health Needs. The Reference Committee endorses the survey which is being conducted at the present time following previous pilot surveys.

(3) Membership Month. The Reference Committee recommends that there be no particular Membership Month but that there be a perpetual drive until all practicing physicians are members of the Michigan State Medical Society.

Mr. Speaker, may I recommend the adoption of the report of The Council to this point. It is not completed, but will be finished at tomorrow's session.

WILLIAM BROMME, M.D. (Wayne): I second the motion.

THE SPEAKER: The motion is that the report of the Reference Committee on Reports of The Council be adopted up to this point. This carries with it the implication that the House of Delegates approves of all that Dr. Weston has said so far. Is there any discussion?

If not, all in favor say "aye"; opposed, "no." The motion is passed and the report is adopted so far.

XII—b. TOKEN OF ESTEEM TO E. R. WITWER, M.D.

C. L. WESTON, M.D.: Mr. Speaker and Members of the House: The Committee on Reports of The Council was handed a resolution which had to do with a member of The Council. Is it your pleasure that I read the resolution in regard to Dr. Witwer?

SEVERAL DELEGATES: No.

THE CHAIR: I think most of us remember the resolution. All in favor of rereading the resolution please raise your hands. The House is not in favor of rereading it. I think we all remember it.

C. L. WESTON, M.D.: The resolution was considered by the Committee and it was unanimously recommended that it be adopted.

Mr. Speaker, I move the adoption of this resolution.

THE SPEAKER: Is there a second?

F. A. WEISER, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion concerning the resolution or concerning the services of Dr. Witwer? If not, those in favor say "aye"; opposed, "no." The motion is passed.

Thank you, Dr. Weston. You will bring in your supplemental report tomorrow, I take it.

The next item on the agenda is the Report of the Reference Committee on Standing Committees, Dr. Earl Krieg of Wayne, Chairman.

XII—c. REPORT OF REFERENCE COMMITTEE ON STANDING COMMITTEES

E. G. KRIEG, M.D. (Wayne): The Reference Committee on Reports of Standing Committees desires to make the following report:

The following reports were accepted without amendments or additions:

XII—c. THE MEDICAL LEGAL COMMITTEE

Report, published on page 65 of the Handbook.

XII—c. PREVENTIVE MEDICINE COMMITTEE

Report including all its subcommittees, published on pages 65-77 of the Handbook.

XII—c. COMMITTEE ON PUBLIC RELATIONS

Report published on pages 83-94 of the Handbook. To this report this morning were added a supplemental report on Radio by Dr. Hull and one on Cinema by Dr. Walls.

Mr. Speaker, I move the adoption of this report.

THE SPEAKER: Is that motion seconded?

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE SPEAKER: The motion is that the reports of the Medical Legal Committee, the Preventive Medicine Committee, the Public Relations Committee and the supplemental report of the Public Relations Committee on Radio and the report on Cinema be adopted as read. Is there any discussion?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

XII—c. REPORT OF LEGISLATIVE COMMITTEE

E. G. KRIEG, M.D.: On page 63 of the Handbook there is the Report of the Legislative Committee, and it was approved with the following recommendation: That the Committee devote strong effort to remove the block in both the Basic Science Law and the requirements of the Board of Registration in Medicine which requires licensure in both the Basic Sciences and in Medicine for residents in training in our State.

Mr. Speaker, I move the adoption of this report with the amendment as read.

THE SPEAKER: Is that motion supported?

R. L. WADE, M.D. (Branch): I support it.

THE SPEAKER: The motion is that the Report of the Legislative Committee be adopted as amended. The amendment concerns the Basic Science Examination and the examination for licensure. Is there any discussion on this subject?

H. L. MORRIS, M.D. (Wayne): Mr. Chairman, that action called for legislative action, both to change the rulings in the Board of Registration and the Basic Science Law.

THE SPEAKER: Dr. Krieg, will you read that phrase again, concerning the action the amendment wishes the State Medical Society to take?

E. G. KRIEG, M.D.: Your Committee adds the following recommendation: that the Committee on Legislation devote strong effort to remove the block in both the Basic Science Law and the requirements of the Board of Registration in Medicine which requires licensure in both the Basic Sciences and in Medicine for residents in training in our State.

THE SPEAKER: Did you understand that, Dr. Morris?

H. L. MORRIS, M.D. (Wayne): Perfectly.

THE SPEAKER: Is there any other discussion?

The amendment is that the Committee devote strong effort to remove the block. Any other discussion?

PRESIDENT LEDWIDGE: Mr. Chairman, I would like to discuss that.

THE SPEAKER: Dr. Ledwidge has devoted considerable effort to this question, probably more than anyone else in the State Society.

PRESIDENT LEDWIDGE: I would like to say, first, that I am not sure I have got exactly straight what your resolution is. If I understand Dr. Krieg correctly, he is suggesting legislative changes. Is that right?

E. G. KRIEG, M. D.: No.

THE SPEAKER: Will you read that again—louder?

E. G. KRIEG: "Recommend that the Committee devote strong effort to remove the block in both the Basic Science Law and the requirements of the Board of Registration in Medicine which requires licensure in both the Basic Sciences and in Medicine for residents in training in our State.

PRESIDENT LEDWIDGE: Does this refer to the Legislative Committee?

E. G. KRIEG, M.D.: The Reference Report of the Legislative Committee.

THE SPEAKER: Dr. Ledwidge, this is a proposed amendment to the report of the Legislative Committee.

PRESIDENT LEDWIDGE: Well, is the Legislative Committee subjecting itself to that strong action in this direction?

E. G. KRIEG, M.D.: That is the intent, gentlemen.

PRESIDENT LEDWIDGE: I would like to discuss that in this way. I am not sure that the Legislative Committee is the proper committee to take that action. The Legislative Committee in its work implies legislative change, and I am not sure that is the easiest or best way to change that.

I would like to say a word or two on the background of my position. During Governor Sigler's administration we had a very good friend in the Governor's office, in the person of his Special Counsel, H. H. Warner. Mr. Warner is very interested in having good committees and good boards, commissions and so on, and he is likewise very interested in the medical question and medical care. He was working quietly under the direction of the Governor and trying to get some change in the administrative rules.

I think if we leave that alone and Warner is back in there, those changes can be made quietly that way. Maybe they won't, but I think they can be.

It is going to be quite a job to change that by legislative action and stop it where you want to stop it. I am not quite sure that the Legislative Committee is the committee to which it should be referred. I am not sure that that might not better be referred to The Council for proper action.

THE SPEAKER: Thank you, Dr. Ledwidge.

With the permission of the House, I should like to read again this phrase, because it seems to me this phrase is in keeping with the remarks that have already been made. This phrase reads like this:

"The report of the Legislative Committee, published on page 63 of the Handbook, was approved by your Committee with the following recommendation, that the committee devote strong effort to remove the block in both the Basic Science Law and the requirements of the Board of Registration in Medicine for residents in training in our State."

In other words, this amendment does not call for removing the Basic Science Law, eliminating it. It says to remove the block which requires licensure in both Basic Science and Medicine for residency. In other words, cut out the obstructions.

Any further discussion?

We are now discussing the motion to approve the report as recommended.

S. L. LOUPEE, M.D. (Cass): I can help out a little on that. I take it the block they refer to is not a legislative block, but a block that pertains to the rules of the committees. The Licensure Board sets up certain rules under the law, and those rules are pretty rigidly adhered to unless some pressure is put on the licensing board to get them to see differently. The same thing is true with the Basic Science Boards. The Basic Science Board has been particularly strict on any intent of the law, as any of us can see by reading the law and reading also their rules.

The way to approach this is, as has been stated here, not through legislative effort, but through some decisive move on the part of somebody who knows these fellows. In fact, the Legislature itself has a committee that has been set up for the purpose of studying these rules of the particular governing boards, and the Basic Science Board was brought before this Legislative Committee, and the thing was pretty well threshed over, and I think with some good results. Perhaps there is no ruling as yet, but I think the movement has been made. It is not legislative. It is executive in purpose and can be remedied through an approach to the executive offices.

THE SPEAKER: Is there any further discussion on the motion?

H. H. RIECKER, M.D. (Washtenaw): Mr. Speaker, may I ask if this Committee considered those men who have passed their specialty boards, coming into the State to practice, where they are required to take the Basic Science Board's examinations? This has kept out a number of very good men who are leading in the states in certain specialties, particularly roentgenology. These men have passed their specialty boards, yet they are required to take the Basic Science examination. Has that been considered by the Committee?

THE SPEAKER: Dr. Riecker, what committee do you mean—Reference Committee or the Legislative Committee or the Special Committee on the Basic Sciences?

H. H. RIECKER, M.D.: By the Legislative Committee.

THE SPEAKER: Is there anyone from the Legislative Committee who would care to answer that question?

Is there any other discussion?

H. L. MORRIS, M.D. (Wayne): I think Dr. Ledwidge brought up this morning that the decision had been made not by the Board of Registration, but a decision handed down by the Attorney General. Now, in spite of your remarks to the contrary, Dr. Loupee, it does not become a question of the Board's ruling. If it is a matter of interpretation by the Attorney General, I think this matter should be handled by The Council of the State Society and not by a Legislative Committee, which is a subcommittee of representatives of the State Society.

Therefore, I make that recommendation.

THE SPEAKER: What recommendation do you make?

Do you care to make it in the form of an amendment?

H. L. MORRIS, M.D. (Wayne): Instead of the question of the licensure and the continuation of postgraduate study by interns or residents, and the question of the Basic Science Board, that it be handled by The Council of the Michigan State Medical Society rather than by the Legislative Committee which is appointed by The President.

THE SPEAKER: The recommendation is not made in the form of a motion. However, it is a recommendation that will appear in the minutes for the consideration of The Council.

Is there any other discussion on the motion that the report be accepted as amended?

PRESIDENT LEDWIDGE: Mr. Speaker, I think you can clarify that point here. If we vote to accept this report, that directs the Legislative Committee to free the block. The Council cannot overrule that. The House of Delegates directs The Council. I think you should change it and recommend that The Council be instructed by the House of Delegates to do what it can to remove this block, instead of the Legislative Committee.

THE SPEAKER: Dr. Ledwidge recommends that The Council take what steps it can to attempt to remove this block, rather than referring it to the Legislative Committee.

PRESIDENT LEDWIDGE: That The Council be instructed by the House of Delegates.

THE SPEAKER: Do you care to make that in the form of an amendment?

PRESIDENT LEDWIDGE: I am not a member of the House.

THE SPEAKER: Dr. Ledwidge is not a member of the House.

E. D. SPALDING, M.D. (Wayne): I move that this matter be referred to The Council to be handled as has been suggested.

THE SPEAKER: Dr. Spalding moves that this matter be referred to The Council for action. That includes this report and amendment —that it be referred to The Council. Is there a second?

R. W. TEED, M.D. (Washtenaw): I second it.

THE SPEAKER: Is there any discussion on the motion that this amendment be referred to The Council for action? If not, all in favor say "aye"; opposed, "no." The motion is passed.

R. S. BREAKEY, M.D. (Ingham): Mr. Speaker, as you ruled, Dr. Spalding's motion was in the form of an amendment to the report.

THE SPEAKER: Dr. Spalding's motion was a motion to refer, which takes precedence over the motion to adopt or amend. Therefore, all we had to do was act on Dr. Spalding's motion. Be sure when Dr. Spalding makes a motion it is right.

XII—c. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

E. G. Krieg, M.D. (Wayne): The report of the Committee on Distribution of Medical Care, as published on page 64 of the Handbook, was accepted with the following recommendation: The committee regrets that this committee has not functioned during the last year and recommends that its duties be reactivated with vigor comparable to the importance of its functions, or that it be absorbed by the Public Relations Committee.

Mr. Chairman, I move the adoption of this report with the amendment.

The Speaker: You have heard the amendment. Is there any discussion on the matter, on the motion that the Report of the Committee on Distribution of Medical Care be adopted as amended, with the suggestion of the Reference Committee?

(The motion was seconded.)

Any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

XII—c. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

E. G. Krieg, M.D. (Wayne): The Report of the Committee on Postgraduate Medical Education, as published on pages 77 to 82 of the Handbook, was accepted by your committee with the following suggestion: that more emphasis be placed on education of the private physician and his place in the public relations picture at the patient-physician level.

Mr. Speaker, I move the adoption of this report as amended.

The Speaker: Is there a second?

R. S. Breakey, M.D. (Ingham): I second the motion.

The Speaker: Is there any discussion on the motion that the report of the Committee on Postgraduate Medical Education be accepted as amended? If there is no discussion, all in favor say "aye"; opposed, "no." The motion is carried.

XII—c. COMMITTEE ON ETHICS

E. G. Krieg, M.D. (Wayne): On page 94 of the Handbook is the Report of the Committee on Ethics. This report was accepted with the following comment: The Committee challenges the last paragraph of the report in the light of the addresses delivered by the officers of the State Society during the first session of the present meeting.

Mr. Speaker, I move the adoption of this report with the amendment.

The Speaker: It has been moved that the Report of the Ethics Committee be adopted as amended, with this suggestion. Is there a second?

T. Y. Ho, M.D. (Clinton): I second the motion.

The Speaker: Dr. Krieg, would you mind reading the last paragraph of that report?

E. G. Krieg, M.D.: This is the paragraph:

"This denotes a very healthy condition of affairs and is evidence of harmony within the profession."

The Speaker: Is there any further discussion?

If not, all in favor of the adoption of the report as amended, say "aye"; opposed, "no." The Chair is in doubt. All in favor raise your right hand please. Hands down. All opposed to the motion raise your hands. The motion is passed.

E. G. Krieg: Mr. Speaker, I move the report of the Committee as a whole be adopted.

The Speaker: Is that motion supported?

E. D. King, M.D. (Wayne): I second it.

The Speaker: It is moved and supported that the report as a whole of the Reference Committee on Standing Committees be adopted. Is there any further discussion?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

Thank you very much, Dr. Krieg, for your very excellent work.

XII—d. ON SPECIAL COMMITTEES

The next item on the agenda is the Report of the Reference Committee on Special Committees. Dr. George Stucky of Eaton County.

G. C. Stucky, M.D. (Eaton): Mr. Speaker, the Reference Committee on Special Committees presents the following report:

XII—d. COMMITTEE ON NURSES' TRAINING SCHOOLS

We recommend adoption of the report of this Committee. We urge that the work it formerly did be carried on by the other committee to which its work was assigned. We also recommend the dissolution of this Committee.

I move the adoption of this report.

The Speaker: You have heard the report of the Reference Committee on Nurses' Training Schools, as amended, recommending the dissolution of this committee. Is there a second?

William Bromme, M.D. (Wayne): I second it.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion passed.

XII—d. SCIENTIFIC RADIO COMMITTEE

G. C. Stucky, M.D. (Eaton): We recommend adoption of the report as printed and wish to commend this Committee for inclusion of programs prepared by practicing physicians. We feel this action broadens the field of interest in the program.

XII—d. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

We recommend the adoption of this report as printed.

XII—d. SCIENTIFIC WORK COMMITTEE

Your Committee recommends adoption of that portion of The Council's report dealing with the Scientific Work Committee. It also wishes to commend highly the Committee for its sterling efforts.

XII—d. BEAUMONT MEMORIAL COMMITTEE

It is recommended that the report of this Committee be adopted as printed. This committee is to be commended for its efforts and its aims.

XII—d. INTERPROFESSIONAL COMMITTEE

Your Committee recommends adoption of this report as printed and urges that knowledge of the aims of the Committee and its work be disseminated through the membership of the Michigan Medical Society.

I move the adoption.

The Speaker: You have heard the motion that the reports of the Scientific Radio Committee, the Advisory Committee to the Woman's Auxiliary, the Scientific Work Committee, the Beaumont Memorial Committee, and the Interprofessional Committee be adopted as amended. Is there a second?

E. G. Krieg, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion on this motion?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

XII—d. COMMITTEE ON RHEUMATIC FEVER CONTROL

G. C. Stucky, M.D. (Eaton): It is recommended that the report be adopted as printed. The Committee is to be highly commended for its work during the past year. Your Committee hopes for the continued success of this program during the coming year.

XII—d. COMMITTEE ON STATE VETERANS AFFAIRS

No report of this committee is available for study.

XII—d. COMMITTEE ON UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

No report of this committee is available for study.

XII—d. COMMITTEE ON RURAL HEALTH

It is recommended that this report be adopted as printed. It is also recommended that the findings of the Michigan Health Survey, now in progress, be made available to member county medical societies on completion of the study and evaluation by the Committee. This Committee is due high commendation for the excellency of its efforts, especially in the matter of the accomplishment of the Second Rural Health Conference, which entailed enormous efforts. We also concur in the recommendation that the Michigan Health Council be reactivated.

XII—d. COMMITTEE ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND

We recommend adoption of the report as printed. We feel that the county societies should take more active measures in support of this program.

XII—d. COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

Your Committee recommends adoption of the report as printed.

XII—d. COMMITTEE ON RED CROSS BLOOD BANK PROGRAM

It is recommended that the printed report be adopted, and that the Supplemental Report rendered on September 20, 1948, likewise be accepted.

XII—d. COMMISSION ON HEALTH CARE

Report accepted with commendation.

I move the adoption of these reports.

The Speaker: Is that supported?

Arch Walls, M.D. (Wayne): I second it.

The Speaker: The motion is that the reports of the Committees on Rheumatic Fever Control, State Veterans Affairs, Uniform Fee Schedule for Government Agencies, Rural Health, Michigan High School Athletic Accident Benefit Fund, National Emergency Medical Service, and Red Cross Blood Bank Program and Commission on Health Care be accepted with the comments. There are no amendments.

Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

G. C. Stucky, M.D. (Eaton): The Committee received a new resolution concerning the care of elderly persons. The Speaker wants to know if it should be read.

The Speaker: Do the members of the House remember the resolution? Would it be satisfactory to the members of the House if the Chairman of the Committee would skip the preamble and read the resolution?

Delegates: Yes.

XII—d. CREATION OF COMMITTEE ON GERIATRICS

G. C. Stucky, M.D. (Eaton):

"Resolved, That the House of Delegates direct the President of the Michigan State Medical Society to appoint forthwith a committee whose duty it shall be:

"(1) To investigate and survey the present facilities for proper and adequate care of the elderly citizen who is in need of it.

"(2) That this be done at the county or district level in co-operation with the county medical societies.

"(3) That the inquiry embrace present facilities for the economically indigent, borderline, as well as the well-to-do.

"(4) That the extent and urgency of the problem be determined, in each county, together with any measures now being taken contributing importantly to its solution.

"(5) That the committee suggest if possible measures by which the organized profession may assume leadership in a field not now adequately served by any other agency.

"(6) That the committee be given adequate financial support for this project in order that a full report can be made to the House of Delegates at its next annual meeting."

Mr. Speaker, I move that this resolution be adopted.

The Speaker: It has been moved that the resolution be adopted. Is there a second?

E. G. Krieg, M.D. (Wayne): I second it.

The Speaker: Is there any discussion on this resolution concerning the aged?

R. S. Breakey, M.D. (Ingham): One question. It asks for financial support. It is rather vague. Who is going to be responsible for that, The Council? Who allocates funds for this Society? Either there should be a stipulation or the authority should be so delegated.

The Speaker: Dr. Stucky, will you read that paragraph again and clarify that item?

G. C. Stucky, M.D. (Eaton): "That the committee be given adequate financial support for this project in order that a full report can be made to the House of Delegates at its next annual meeting."

It doesn't say who.

The Speaker: Does that satisfy the delegates?

R. S. Breakey, M.D. (Ingham): No sir. I don't know what "adequate financial support" is, nor who is going to furnish it nor judge it.

Mr. Speaker and Gentlemen: I think the resolution should specifically authorize a certain amount of money, or it should delegate that authorization to The Council. Adequate financial support might be $10 and it might be $1000.

I think there should be some clarification, not that I am in disagreement with whatever adequate support is, but it should be stated. Therefore, I offer an amendment, that the words "at the discretion of The Council" be added after "adequate financial support for this project."

The Speaker: It is moved that the words "at the discretion of The Council" be added to the last paragraph. Is there a second?

H. W. Wiley, M.D. (Ingham): I support it.

The Speaker: Is there any discussion on the amendment that these words be added—"*at the discretion of The Council*"?

If not, all in favor say "aye"; opposed, "no." The amendment is passed.

Is there any discussion on the original motion that the resolution be adopted as amended? If not, all in favor say "aye"; opposed, "no." The motion is passed and the resolution is adopted as amended.

Dr. Stucky, do you have any other resolution?

G. C. Stucky, M.D. (Eaton): Mr. Speaker, we have a resolution submitted by Dr. Robson of Ingham County.

XII—d. REQUISITES FOR NURSE TRAINING

"Whereas, There has been an increasing shortage of available registered nurses for the staffing of hospitals, and for private duty either in hospitals or homes; and

"Whereas, This shortage has been acutely felt throughout the entire country, to the extent that even governmental agencies have endeavored to increase the number of students in nurses' training schools; and

"Whereas, At a recent national meeting it was proposed that training schools for registered nurses be limited to larger teaching or university hospitals, thus greatly diminishing the present number of training schools for registered nurses; and

"Whereas, As proposed, student nurses in smaller or nonteaching hospitals would be trained only as 'practical nurses,' with a two-year course, to supplant registered nurse trainees or graduates, thereby lowering the standards of training below that now required in nurses' training schools; and

"Whereas, The proposed increased prenursing school requirements will without doubt result in fewer applicants for such training; therefore, be it

"RESOLVED, That through its House of Delegates, the Michigan State Medical Society deplore and strongly oppose any such step which would reduce the number of trained nursing personnel or substitute an inferior training for the present registered nurses' course of training as currently conducted in all of the hospitals accredited for such courses; and further be it

"RESOLVED, That the program for training nurses aides be continued and encouraged, but not, however, at the expense of the existing training and qualifications for registered nurses, and further be it

"RESOLVED, That any further educational prerequisites for this profession be reserved for that group of nurses who elect to prepare themselves for specialized nursing or for instructorships in schools of nursing, thereby elevating the standards of training in all of the now existing schools for registered nurses and further improving the calibre of this vital profession."

Mr. Chairman, the Committee moves the adoption.

The Speaker: You have heard the motion that the resolution be adopted as read. Is there any support?

William Bromme, M.D. (Wayne): I second it.

The Speaker: Is there any discussion on this motion regarding nurses training?

E. J. Robson, M.D. (Ingham): Just a very brief comment. I presented this resolution this morning, and I neglected to say that this resolution has received a very thorough going over by the Executive Committee. This was not an individual resolution as presented by me. It was presented on behalf of the Ingham County Medical Society.

The Speaker: Is there any further discussion?

W. B. Harm, M.D. (Wayne): It looks to me as if we are leaving our field of authority. I don't know why we should tell the nurses what to do. We are telling them how far they can be educated and how far they can't be educated. I think that is their business to find out. If they are not capable, we can inquire about the hospital. But to tell them that only certain nurses can be educated so far and certain nurses can only have so much education, it looks to me as if we are restricting other people's business, and there is enough of that going on today.

The Speaker: Is there any further discussion?

R. S. Breakey, M.D. (Ingham): I don't think Dr. Harm listened to this resolution very closely. It is not the purpose of the resolution to instruct nursing care at all, but to deplore the depletion.

About ten months ago there was a meeting in Chicago, in which it was proposed that all graduate nurses be required to take a four-year collegiate course, that for the standards of nursing there be substituted two-year courses, and that qualifications for licensure, or what have you, for the average local hospital be rescinded, and only large universities or teaching centers be permitted to graduate registered nurses.

The important thing is, Dr. Harm, that if that happens we will have no nurses training school in Lansing, Michigan, and I don't think you will have nurses training schools in even some of the larger Detroit hospitals.

This is not to dictate how the training is to be done, but we are concerned with medical associates and bringing up as many different associates with medicine as Dr. Pino did in this report, which costs us money. We had better be concerned with the nurses training schools or we as doctors won't have the help we need.

This is not to instruct how to teach. It is to deplore the possible loss or the lowering of the teaching standards to a two-year training program.

I hope the House will see the purport and intent of this resolution. It is not to tell anybody anything, but these nurses are our right hands.

The Speaker: The Chair would like to reread that one phrase which is being discussed.

"Resolved, That through its House of Delegates, the Michigan State Medical Society deplore and strongly oppose any such step which would reduce the number of trained nursing personnel or substitute an inferior training for the present registered nurses' course of training"—

Is there any further discussion?

W. D. Barrett, M.D. (Wayne): Mr. Speaker, it is seldom that I disagree with Dr. Harm, because Dr. Harm is usually right. I think he is right tonight, except that I think he feels that the medical profession may be overstepping its mark by interfering with the hospital in the training of nurses.

I don't think that we should interfere with the hospitals in the training of nurses, but at the same time I think there should be a closer co-operation between the nursing profession and the medical profession. At this time there is not that close co-operation which we should have. I don't know exactly how it can be arrived at, but unless it is arrived at, there are going to be fewer nurses.

The nurses depend upon the medical profession for their teaching, for their training. We depend upon the nurses for help. The patient depends upon the nursing profession and the medical profession. The hospitals depend upon them all.

Unless we have closer co-operation, which I do think this resolution is bringing out, I think we are going to be in worse straits than we are at the present time. Thank you.

The Speaker: Is there any further discussion on the motion? The motion is to adopt the resolution.

H. L. Morris, M.D. (Wayne): Mr. Chairman, I heard a lot of discussion in the last few days about how long it takes a nurse to learn her duties as a nurse. During the past war emergency a lot of helpers came into the hospital. The helpers could sweep the floor and make the beds and rustle the bedpans. In my opinion, it does not take three or four years to teach a girl, who is intelligent, who has some pre-nursing academic training, to do a good job at nursing. Therefore, I would oppose laying down a rule that they must have three years or any specified amount of training to do the things which the hospitals make use of so they do not have to hire other help.

These nurses pay a tuition fee, and they are on for three years, which is a good investment for the hospital. They are working there and doing a lot of menial tasks which are not particularly important, insofar as the bed patient is concerned, relative to the care of the sick. Once they learn how to do the menial jobs of rustling the bedpan, making the beds and sweeping the floor, it doesn't take them three months or six months to keep on doing that. I think we should not insist upon the prescribed three-year term of nursing service to make them graduate nurses.

The Speaker: The Chair would like to read the next sentence of this resolution to clarify it.

President Ledwidge: Please read the whole resolution so we can understand it. I don't understand it, and I doubt if the others do.

The Speaker: All right. I will read the resolution.

(The Speaker read the entire resolution.)

President Ledwidge: What steps are they deploring? That is what I don't understand.

The Speaker: Then it will be necessary to read the preamble. I will read the preamble.

(The Speaker read the preamble of the resolution.)

Is there any further discussion on the motion to adopt this resolution?

H. G. Huntington, M.D. (Livingston): I move it be referred back to the Committee. It is so ambiguous that nobody seems to understand what it is.

The Speaker: The motion is that the resolution be referred back to the Reference Committee for clarification and re-presentation to the House. Is there a second?

E. D. Spalding, M.D. (Wayne): I second the motion.

The Speaker: This motion is debatable. Is there any discussion on this motion to refer this resolution back to the Committee?

If there is no discussion, the Chair will ask for a showing of hands. All in favor of referring this resolution back to the Committee for reconsideration raise your hands. All who are opposed to referring the resolution back to the Committee raise your hands. The "noes" have it. Therefore, the resolution is still up for consideration. Is there any further discussion on the resolution.

(Calls for the question.)

If there is no further discussion, the Chair will call for a vote. All who are in favor of the motion to adopt the resolution as read say "aye"; opposed, "no." The motion is passed.

Does the Chairman of the Reference Committee have any further business?

G. C. Stucky, M.D. (Eaton): Mr. Speaker, I move that the whole report of the Committee be adopted.

The Speaker: The motion is that the entire report of the Reference Committee on Special Committees be adopted as amended. Is there any support?

T. Y. Ho, M.D. (Clinton): I second the motion.

The Speaker: All in favor say "aye"; opposed, "no." Motion is passed.

The next item on the agenda is the Report of the Reference Committee on Amendments to the Constitution and By-Laws. Dr. Spalding, as Chairman of the Committee, do you have a report?

E. D. Spalding, M.D. (Wayne): I have a partial report, but due to the fact that the matter should be considered as a whole, I suggest that it be delayed until the Committee has finished its work, which will be in an hour or two, and we will present it at tomorrow morning's session.

The Speaker: The Chair will withhold the report.

XII—e. ON RESOLUTIONS

The next item on the agenda is the Report of the Reference Committee on Resolutions. Do you have a report, Dr. Bromme?

William Bromme, M.D. (Wayne): Yes.

The Speaker: While Dr. Bromme is coming up, may I say there are some gentlemen of the press with us, and we are glad to have them with us. We hope you will clear your releases with the members of the Press Committee.

William Bromme, M.D. (Wayne): Mr. Speaker and Members of the House: Six resolutions have been presented and discussed by your Committee.

The first resolution for discussion is one presented by Dr. Krieg of Wayne, with reference to a medical library service. If there is no objection on the part of the House, I will not read the preamble but only read the resolution.

XII—e. CREATION OF MEDICAL LIBRARY SERVICE

"Resolved, That this House of Delegates instruct the Committee on Postgraduate Teaching, or other suitable committee, to meet with the State Library Commission at an early opportunity with the purpose in mind of establishing a medical library service similar to that now operating in the State of Iowa."

The Reference Committee on Resolutions approves this resolution, and I move that the resolution be adopted.

W. B. Harm, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion on the motion to adopt the resolution? If not, all in favor say "aye"; opposed, "no." It is passed.

William Bromme, M.D. (Wayne): The second resolution which was referred to the Committee bears the unanimous approval of the Committee. It relates to the life service of medicine by Dr. A. V. Wenger.

XII—e. RECOGNITION OF FORTY-SIX YEARS ATTENDANCE BY H. V. WENGER, M.D.

Mr. Speaker, I move that this resolution be adopted.

The Speaker: Is this motion supported?

D. C. Bloemendaal, M.D. (Ottawa): I support it.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

(The audience rose and applauded.)

XII—e. CONSULTATION OF DOCTORS OF MEDICINE WITH OSTEOPATHS (see page 1268)

William Bromme, M.D. (Wayne): The third resolution presented to the Reference Committee for study was presented by Dr. Wiley of Macomb County, relative to a situation which has arisen in that area and perhaps in other parts of the state, involving occasional types of consultation between Doctors of Medicine and osteopaths who have patients in an osteopathic hospital and desire consultation. If you would like me to read the entire preamble, I would be happy to do so. The preamble is as follows:

"Whereas, Certain members of the Macomb County Medical Society have been asked to examine patients in consultation in the Mount Clemens General Hospital, an Osteopathic Hospital, and

"Whereas, Frequently, in cases of emergency, patients of Doctors of Medicine have been taken to the Mount Clemens General Hospital, and

"Whereas, The number of Osteopaths in Macomb County is more than half the number of Doctors of Medicine, and

"Whereas, It is probable that similar situations have occurred, or will occur, in other parts of the state; be it therefore

"RESOLVED, That the Macomb County Medical Society desires to have clarified the status of consultation of Doctors of Medicine with Osteopaths on serious cases, and the question of Doctors of Medicine professionally visiting their patients who have been taken to an Osteopathic Hospital as an emergency case, when their condition is such that transfer to another hospital is not advisable."

The consensus of your Reference Committee is that the House of Delegates of the Michigan State Medical Society is without authority to act on this, and that this matter is completely covered by the Code of Ethics of the American Medical Association.

I move that the action of your Reference Committee be approved by the House.

The Speaker: Motion concerning this resolution is that the action of the Reference Committee be approved by the House of Delegates. Is there a second?

L. J. Bailey, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion on this motion?

L. W. Gerstner, M.D. (Kalamazoo): I don't have to say too much, because this has not come up in our society. I would suggest that this does not offer the people asking for advice really any concrete help. They know the Code of Ethics, but they are faced with the situation that I wish could be clarified a little better for the men who are asking help. This is the body who can help them.

W. B. Harm, M.D. (Wayne): In recent days I have made quite a study of the Code of Ethics of the American Medical Association. There are a lot of things in there I couldn't find, and this is one of them. Many of us men will soon have to go to osteopathic hospitals if we want to work and practice medicine.

Therefore, I move that this resolution be sent back to the Resolutions Committee for clarification and decision.

The Speaker: The motion which Dr. Harm makes is that this

resolution be sent back to the Resolutions Committee for consideration.

W. B. HARM, M.D. (Wayne): Any decision?

H. W. WILEY, M.D. (Ingham): I second the motion.

THE SPEAKER: Is there any discussion on the motion to refer this resolution back to the Resolutions Committee? If not, all in favor of referring the resolution back to the Committee say "aye"; opposed, "no."

The motion is passed. The resolution is referred back to the Resolutions Committee.

Now, I would like to ask, in referring this resolution back to the Resolutions Committee, does the House care to instruct the Resolutions Committee in any way? The Chair will hold the motion open for a few minutes to see if there are any instructions the House desires to give the Committee.

R. W. TEED, M.D. (Washtenaw): Mr. Chairman, this is a matter which has come up in our community and will continue to come up, but I think that the guiding principle in the solution of these problems should be the benefit of the patient. I do not believe that we should allow professional pride and too much reliance on ethics to guide our opinion here. It should be the patient, and that is all there is to it.

THE SPEAKER: Does the House care to make any instructions to the Resolutions Committee?

THE SPEAKER: If there are no instructions forthcoming, we will proceed with the order of business.

W. W. BABCOCK, M.D. (Wayne): Mr. Speaker and Gentlemen of the House: This particular item is a hot potato, and it is the type of thing that we do not particularly care to get too much publicity on. Yet at the same time, we must realize that it is a vital problem to certain counties of the State Society.

The problem has several aspects. One is that it is a problem that we do not care to have a lot of publicity on. Another one is that it is a vital problem regarding many individual county societies, and it is something that we must not ignore.

I wonder if the solution might not be in Dr. Bromme's committee recommending to The Council that those problems be cared for by the local county societies on a county level. I know that the problems in Monroe would be definitely different than they are in Wayne, and that probably would be true throughout the state. I doubt very much if a state ruling could be made which would be fair to all.

THE SPEAKER: Do you care to propose any motion at all?

W. W. BABCOCK, M.D. (Wayne): I feel that the motion should come from Dr. Bromme's Committee. I merely wish to leave the thought for them to work on.

THE SPEAKER: The resolution has been referred back to the Committee. Is there any further discussion? There is no motion on the floor.

R. S. BREAKEY, M.D. (Ingham): Mr. Speaker, will you ask Dr. Denham of Kent to discuss this?

THE SPEAKER: The request comes from the floor to ask Dr. Denham to discuss this matter before the resolution is taken back to the Committee. Does Dr. Denham care to discuss the matter?

W. B. HARM, M.D. (Wayne): There is a motion on the floor. I rise to a point of order.

THE SPEAKER: The Chair believes there is no motion on the floor, that the motion to refer this back to the Committee was passed. The Chair simply asked for advice from the floor for the Committee to guide them in their deliberations. Is Dr. Denham here to discuss this?

R. H. DENHAM (Kent): I don't care to discuss it.

THE SPEAKER: Dr. Denham does not care to discuss it.

The Chair would suggest that when the Resolutions Committee meets, if the members of the House have suggestions on this, they appear before the Committee.

Is there anything further, Dr. Bromme?

WILLIAM BROMME, M.D. (Wayne): Oh, yes, we have lots of resolutions. Many of them are phrased in a very difficult pattern for the Resolutions Committee. There are some which I think are actually out of the purview, out of the field of activity, of the Resolutions Committee per se.

XII—e. COMPREHENSIVE PRACTICE ACT

A resolution proposed by Dr. Owen of Wayne, a resolution regarding the Medical Practice Act. Would you like it to be read in its entirety, or simply the recommendation or the resolution itself?

THE SPEAKER: Is it adequate for the House to read the resolution alone?

WILLIAM BROMME, M.D. (Wayne): "RESOLVED, By the House of Delegates, that the Michigan State Medical Society, through appropriate committee and in co-operation with other members of the healing art duly authorized to practice medicine by licensure, do sponsor a comprehensive law which will have for its purpose the regulating and licensing of all phases of the healing art."

Your Reference Committee requested the advice of a good many people, and it develops that the present Medical Practice Act is not necessarily obsolete or chaotic, as phrased in the preamble of this resolution, and from the evidence in hand there is some question as to whether a simple standard is applicable for the license of all forms of the healing art.

We believe this matter is one for further high level discussion—that is, on the national level—and your Reference Committee recommends that action be postponed indefinitely.

I so move.

THE SPEAKER: You have heard the motion that action on this resolution be postponed indefinitely. Is there a second to this motion?

H. H. RIECKER, M.D. (Washtenaw): I second it.

THE SPEAKER: Is there any discussion on the motion that action on this resolution be postponed indefinitely?

W. B. HARM, M.D. (Wayne): Mr. Chairman, again I am getting tired of talking. At the same time, this thing has been postponed for seven or eight years, it has actually been on the board. Before that it was talked about for about twenty years. It is time you got to the conclusion of it.

THE SPEAKER: Is there any other discussion on the motion to postpone action indefinitely?

If there is no other discussion, all in favor of the motion to postpone action indefinitely say "aye"; opposed. "no." The motion is passed.

Dr. Bromme!

XII—e. V. A. HOSPITAL IN ANN ARBOR

WILLIAM BROMME, M.D., (Wayne): A resolution introduced by Dr. Spalding of Wayne, regarding Veterans Hospitals.

I must read all of it, because the Committee changed the phrases of some parts of it.

"Whereas, The Veterans Administration proposes to establish and operate a five hundred bed general hospital near Ann Arbor in conjunction with the Medical School of the University of Michigan, and

"Whereas, This proposal is part of an over-all plan of the Veterans Administration to establish throughout the United States for veterans' care hospital facilities to a total of 300,000 hospital beds, and

"Whereas, The number of hospital beds, approximately 118,000, now available for veterans' care is far in excess of any present or reasonably anticipated future needs for care of service-connected disability, and

"Whereas, A majority of the persons now occupying Veterans Administration Hospital beds have no service-connected disability or illness whatsoever, and

"Whereas, The present facilities of the University Hospital at Ann Arbor are adequate for the care of indigents referred there under State law, therefore, be it

"RESOLVED, That the Veterans Administration should provide veterans with the best of medical and hospital care in all cases of service-connected disability, and with the ultimate in hospital accommodations and equipment necessary to facilitate such care, and be it further

"RESOLVED, That medical or hospital care in other than service-connected disabilities should be furnished our citizens at government expense on the basis of economic need only, and without reference to service with the armed forces, and be it further

"RESOLVED, That based on these principles, the number of hospital beds in Veterans Administration Hospitals should be limited to the number required to care for service-connected disabilities only, and be it further

"RESOLVED, That to establish a Veterans Administration General Hospital near Ann Arbor at this time is not necessary and not in the best interest of the public, and be it further

"RESOLVED, That a copy of these resolutions be sent to the Regents of the University of Michigan, to the Dean of the University of Michigan Medical School, to the Dean of Wayne University College of Medicine and to its governing body, to each State Medical Society, and to the Board of Trustees of the American Medical Association, and be it further

"RESOLVED, That our delegates to the American Medical Association be instructed to present or support similar resolutions to the House of Delegates of the American Medical Association at its next meeting."

Your Reference Committee again utilized the accessibility of personnel in our own House of Delegates who know the situation from specialized points of view.

The Resolutions Committee recommends two deletions in the preamble, just to keep the record a little straighter. There are several things that could be questioned, incidentally, but this is a little beside the point.

The figure 300,000 beds is a figure we think proposed by a service organization, not by an agency which really knows about what the hospital beds needs are. Those figures do creep into the things that come to us in the press. We don't know the source of the 300,000 beds, but that is that.

We do disagree with the statement, "a great majority of the persons now occupying Veterans Administration Hospital beds have no service-connected disability or illness whatsoever." We suggest that the word "great" be removed, so that the preamble as amended will read:

"Whereas, The majority of the persons occupying"—as in our local experience there is not an overwhelming preponderance. We want to keep the statement correct in that way.

The second amendment is to the preamble where it says—"Whereas, The present facilities of the University Hospital at Ann Arbor are adequate for teaching purposes, as well as for the care of indigents referred there under State Law."

We would change that to read: *"Whereas, The present facilities of the University Hospital at Ann Arbor are adequate for the care of indigents referred there under State law."*

With those two amendments to the preamble, this resolution has the approval largely of the practicing physicians of the state of Michigan, and your Reference Committee moves its adoption as amended. I so move.

THE SPEAKER: Is this motion supported?

B. M. HARRIS, M.D. (Washtenaw): I support it.

THE SPEAKER: Is there any discussion on the motion to adopt the resolution as amended?

O. K. ENGELKE, M.D. (Washtenaw): Is it the Committee's intent to send this resolution to everyone but the Veterans Administration?

THE SPEAKER: Will the Chairman of the Committee answer that question?

WILLIAM BROMME, M.D. (Wayne): The Chairman of the Committee wondered about that, too, as a matter of fact, because there are lots of other things in this, if we wanted to get technical about it. As a matter of fact, we don't know why this shouldn't go to the Senior and the Junior Senator of the State of Michigan, because there recurs in this proposition "service-connection versus non-service-connected disability." That, unfortunately, was not taken care of by meetings of medical schools or governing bodies, but by the 1944 Congress. But we have subscribed to the distribution of this as proposed by the proposer of the resolution.

THE SPEAKER: Is there any other discussion? If any member of the House of Delegates feels this resolution should be sent to anyone else except those listed, it is his privilege to propose that amendment. Is there any discussion or any amendment proposed?

E. D. SPALDING, M.D. (Wayne): I would like to hear Dr. Barker of Ann Arbor on this subject. I am sure he has some views.

THE SPEAKER: Dr. Spalding asks that Dr. Barker of Ann Arbor give us his views on the subject.

P. S. BARKER, M.D. (Washtenaw): My only comment is that I believe we need more teaching beds in the University Hospital setup in Ann Arbor. There are many aspects to this problem with which you are more familiar than I.

THE SPEAKER: Is there any further discussion on the motion to adopt the resolution as amended? Is there any discussion? Are you ready for the vote?

If there is no discussion, all in favor of adopting the resolution, of passing the motion to adopt the resolution as amended, say "aye"; opposed, "no." The motion is passed.

XII—e. FORMATION OF NATIONAL AGENCY FOR VOLUNTARY HEALTH SERVICE PLANS

WILLIAM BROMME, M.D. (Wayne): A further resolution, read by Dr. Baker of Oakland County, in reference to enabling phenomena from the House of Delegates to the Michigan State Medical Society to the Board of Trustees, in the Medical Service in one instance, in the matter of proceeding to the formation of the National Agency of Voluntary Health Care, and a similar one to the Michigan Delegates to the American Medical Association, to be instructed to present a resolution to the same general effect.

This matter was gone over this afternoon with much comment. It is also in our hands to present to you, because after all the House of Delegates of the State Society is not the Board of Directors of the Michigan Medical Service, so there is some overlapping.

I should like to read the two sections of the resolution, because your Reference Committee believes they should be dealt with separately and not as unit phenomenon.

The first of these sections of the resolution is as follows:

"THEREFORE, BE IT RESOLVED that this House of Delegates of the Michigan State Medical Society instruct the Board of Directors of Michigan Medical Service to encourage and proceed to the formation of a National Agency for voluntary health service plans."

That is the first section. The second section is:

"BE IT FURTHER RESOLVED that the Michigan Delegates to the American Medical Association be instructed to present a resolution to the House of Delegates of that Association, urging the American Medical Association to exert its support and encouragement to extend Voluntary Health Service Plans in areas not now served and the inclusion of such plans into a national agency."

Your Reference Committee recommends the adoption of the first of these sections as an individual phenomenon—that is, that this House of Delegates instruct the Board of Directors of the Michigan Medical Service to encourage and proceed in the formation of a National Agency for Voluntary Health Service Plans—period.

THE SPEAKER: What is your motion?

WILLIAM BROMME, M.D. (Wayne): The motion is that this resolution be adopted.

THE SPEAKER: Is that part of the resolution—what you read?

WILLIAM BROMME, M.D. (Wayne): Yes.

THE SPEAKER: The motion is that that part of the resolution be adopted. The second part is not included in the motion. Is there a support to that motion?

W. S. REVENO, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion?

I should like to point out that according to the phraseology Michigan Medical Society House of Delegates is instructing the Board of Directors of the Michigan Medical Service, which is quite impossible. We do not instruct the Board of Delegates of another corporation.

Is there any discussion?

W. B. HARM, M.D. (Wayne): Question.

THE SPEAKER: If there is no further discussion—

S. L. LOUPEE, M.D. (Cass): I would just like to know why we are meddling in this matter at all. It was taken care of this afternoon.

Those of you who were here this afternoon and heard the discussion in the Michigan Medical Service meeting know full well that the action was taken, or at least that the decision was made, that the Michigan Medical Service should proceed to encourage national action on this matter. That being the case, unless we want to refute what they have done, unless we want to disapprove what they have done—and I am quite sure we don't—why take it up at all? It is past. We are not encouraging them; we are not discouraging them. It is done. Isn't that enough?

THE SPEAKER: Is there other discussion?

WILLIAM BROMME, M.D. (Wayne): I merely wish to reiterate that this is being brought to the attention of the House of Delegates tonight because this resolution was presented at the first session this morning to the Speaker and transferred through him to our Committee, and we have no alternative but to present this business to the House of Delegates.

The meeting this afternoon was not a meeting of the House of Delegates of the Michigan State Medical Society, if my interpretation is correct.

THE SPEAKER: Is there other discussion on the motion?

S. W. INSLEY, M.D. (Wayne): Mr. Speaker and Fellow Members: As I pointed out this afternoon, I am not so sure as to where we are going on this matter of national incorporation. In regard to this particular motion brought out here tonight, I have not too much to say about it, except to bring up this one point. I would like, if you wish to vote on this matter tonight, to suggest that the motion be qualified by some such clause to the general effect that this be followed through to keep in mind the best interest of the Michigan doctors as it may appear from time to time.

I make this suggestion with due regard for the fact that nobody in this hall tonight knows quite where we are going. I thank you.

I will make that suggestion in the form of a motion—as an amendment to the original motion.

E. D. SPALDING, M.D. (Wayne): Mr. Chairman, is this motion in order, in view of the fact that we have no control over the Michigan Medical Service, which is an entirely different corporation?

THE SPEAKER: Dr. Spalding is raising a point of order as to whether this motion is in order. The Chair believes that any motion that a delegate cares to make, regarding the disposition of a resolution, is in order, whether it is logical or not. The business at hand is an amendment which has been proposed by Dr. Insley to the effect that the words—"keeping in mind the best interests of"—I would like to have you reword that, Dr. Insley.

S. W. INSLEY, M.D. (Wayne): In the first place, *the amendment would apply to a change in the wording from "instruct" to "advise;"* and secondly, that a qualifying clause be put in to the general effect that we shall keep in mind at all times the best interests of the Doctors of Medicine in Michigan as they may appear from time to time.

THE SPEAKER: You have heard the amendment which is proposed. Is the amendment supported?

R. H. BAKER, M.D. (Oakland): I second it.

THE SPEAKER: Is there any discussion on the amendment?

O. K. ENGELKE, M.D. (Washtenaw): I would like to suggest that possibly the amendment might read *"keeping in mind the best interests of the people of the State of Michigan,"* rather than to the doctors of the State of Michigan.

THE SPEAKER: Does Dr. Engelke care to add that as an amendment to the amendment?

O. K. ENGELKE, M.D. (Washtenaw): Yes.

THE SPEAKER: Dr. Engelke proposes to amend the amendment by adding "and the people of the State of Michigan." Is there any support to the amendment Dr. Engelke proposed?

W. B. HARM, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion on the amendment to the amendment? If not, all in favor of Dr. Engelke's amendment that the words "of the people" be added, say "aye"; opposed, "no." The amendment is passed.

The floor is now open for discussion on the amendment proposed by Dr. Insley. Is there any discussion on the amendment, the change of words? If not, all in favor of the amendment say "aye"; opposed, "no." The amendment is passed.

Is there any further discussion on the original motion, that the resolution be adopted as amended? If not, all in favor say "aye"; opposed, "no." The Chair will ask for a standing vote. We are voting on the recommendation of the Resolutions Committee, that this resolution be passed as amended. All in favor of the motion to pass the resolution as amended will please rise. Will the Secretary please count? Please be seated. All those opposed to the passing of the motion to adopt the resolution please rise. The motion is passed.

Do you have further resolutions?

WILLIAM BROMME, M.D. (Wayne): As the second half of this original resolution, we propose the acceptance of this:

"BE IT FURTHER RESOLVED, That the Michigan Delegates to the American Medical Association be instructed to present a resolution to the House of Delegates of that Association, urging the American Medical Association to exert its support and encouragement to extend Voluntary Health Service Plans in areas not now served and the inclusion of such plans into a National Agency."

This second section has the approval of your Reference Committee on Resolutions as a separate entity and I move its adoption.

THE SPEAKER: Is that supported?

B. M. HARRIS, M.D. (Wahstenaw): I second the motion.

THE SPEAKER: Is there any discussion on the motion to adopt

this part of the resolution? Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

Dr. Bromme states there is further business to be reported at a later meeting of this session.

Dr. Bromme says the Committee will meet in the same room in which they met before, at the conclusion of this meeting, which will not be long, I assure you.

XII—f. ON SPECIAL MEMBERSHIPS

The next item on the agenda is the report of the Reference Committee on Special Memberships, Dr. Lightbody of Wayne.

J. J. Lightbody, M.D. (Wayne): Mr. Speaker, the Reference Committee on Special Memberships has received recommendations for special membership from the people from the various societies, and the qualifications of these men have been found to be in accordance with our present Constitution and By-laws.

The following men have been approved, by unanimous consent of the Committee, for life membership of the Michigan State Medical Society.

Charles C. Flinn, M.D.	Allegan
G. H. Rigterink, M.D.	Allegan
J. H. Van Ness, M.D.	Allegan
J. W. Purdy, M.D.	Alpena
John C. Benson, M.D.	Genesee
Orill Reichard, M.D.	Genesee
James W. Barnebee, M.D.	Kalamazoo
J. B. Jackson, M.D.	Kalamazoo
E. D. Sage, M.D.	Kalamazoo
F. A. Pratt, M.D.	Kalamazoo
P. S. Hardy, M.D.	Lenawee
F. A. Howland, M.D.	Lenawee
Lucius A. Farnum, M.D.	Oakland
Edward V. Howlett, M.D.	Oakland
David E. Bagshaw, M.D.	Saginaw
C. D. Brooks, M.D.	Wayne
J. E. Gleason, M.D.	Wayne
H. E. Grant, M.D.	Wayne
G. W. Robinson, M.D.	Wayne
D. L. Sherwood, M.D.	Wayne
Carlos Shotwell, M.D.	Wayne
Albert Wehenkel, M.D.	Wayne
Walter D. Ford, M.D.	Wayne
L. J. Hirschman, M.D.	Wayne
C. E. Simpson, M.D.	Wayne
Charles L. Washburne, M.D.	Washtenaw
W. C. Wylie, M.D.	Washtenaw
Andros Gulde, M.D.	Washtenaw

The following men have been approved by unanimous consent of the Committee for Emeritus Membership:

William L. Helkie, M.D.	Berrien
N. A. Herring, M.D.	Berrien
G. W. Moll, M.D.	Delta-Schoolcraft
C. M. Baskerville, M.D.	Gratiot-Isabella-Clare
H. H. Loveland, M.D.	Lenawee
I. L. Spalding	Lenawee
Henry E. Perry, M.D.	Luce
H. B. Britton, M.D.	Washtenaw
John B. Morton, M.D.	Wayne
Noah E. Aronstam, M.D.	Wayne
Duncan A. Campbell, M.D.	Wayne

The following men have been approved for Associate Membership. Most of these men come from Washtenaw County.

William Asher, M.D.	Washtenaw
Arthur Allen, M.D.	Washtenaw
Charles Aldridge, M.D.	Washtenaw
Robert Berry, M.D.	Washtenaw
George R. Barry, M.D.	Washtenaw
William Brownlee, M.D.	Washtenaw
William Butler, M.D.	Washtenaw
Thomas Brill, M.D.	Washtenaw
Dolphus Compere, M.D.	Washtenaw
William Cheney, M.D.	Washtenaw
James I. Collins, M.D.	Washtenaw
W. R. Craig, Jr., M.D.	Washtenaw
M. S. DeWeese, M.D.	Washtenaw
Arthur Dalton, M.D.	Washtenaw
Eugene Donovan, M.D.	Washtenaw
Ivan Duff, M.D.	Washtenaw
Robert Fish, M.D.	Washtenaw
John K. Fulton, M.D.	Washtenaw
A. A. Goldman, M.D.	Washtenaw
Devitt Gordon, M.D.	Washtenaw
Alex Gotz, M.D.	Washtenaw
A. E. Gulick, M.D.	Washtenaw
Jack Gustafson, M.D.	Washtenaw
W. C. Hall, M.D.	Washtenaw
S. F. Horne, M.D.	Washtenaw
Raymond S. Jackson, M.D.	Washtenaw
Curtis Jones, M.D.	Washtenaw
W. King, M.D.	Washtenaw
Arnold Kambly, M.D.	Washtenaw
Harry Lusk, M.D.	Washtenaw
William Kay Locklin, M.D.	Washtenaw
Manuel Levin, M.D.	Washtenaw
Thomas Lamberti, M.D.	Washtenaw
Martin List, M.D.	Washtenaw
John R. McNichols, M.D.	Washtenaw
Tate Mason, M.D.	Washtenaw
Merle Musselman, M.D.	Washtenaw
Ralph Mahon, Jr., M.D.	Washtenaw
Sylvester O'Connor, M.D.	Washtenaw
Max Parrott, M.D.	Washtenaw
Beverly Payne, M.D.	Washtenaw
Peter Rowe, M.D.	Washtenaw
William H. Reiff, M.D.	Washtenaw
Robert Sweet, M.D.	Washtenaw
John W. Strayer, M.D.	Washtenaw
Henry K. Schock, Jr., M.D.	Washtenaw
Wayne Stewart, M.D.	Washtenaw
Hyman Shapiro, M.D.	Washtenaw
Madison Thomas, M.D.	Washtenaw
Arthur C. Thompson, M.D.	Washtenaw
Daniel C. Thompson, M.D.	Washtenaw
George D. Taylor, M.D.	Washtenaw
Arthur H. Ulmer, M.D.	Washtenaw
Edwin Wright, M.D.	Washtenaw
Arnold Wollum, M.D.	Washtenaw
Keith E. Weller, M.D.	Washtenaw
William F. Weeks, M.D.	Washtenaw
Warren Weisinger, M.D.	Washtenaw
Jerome Yared, M.D.	Washtenaw
Herbert Zatzkin, M.D.	Washtenaw
E. W. May	Wayne

Those have been approved for Associate Membership.

Mr. Chairman, I move the adoption of these resolutions for Special Membership.

The Chairman: You have heard the motion. Is it supported?

T. Y. Ho, M.D. (Clinton): Second the motion.

The Speaker: Is there any discussion of the motion to grant special memberships to those named?

J. E. Livesay, M.D. (Genesee): As a member of this Committee, I was aware, during the reading of these names, that the name of Dr. Benjamin Goodfellow of Genesee County was omitted from the reading. I would like to be sure that it was present on that list.

J. J. Lightbody, M.D. (Wayne): What type of membership?

J. E. Livesay, M.D. (Genesee): Life Membership.

J. J. Lightbody, M.D. (Wayne): He is not on this approved list.

There have been quite a number of men whose names have been sent in, approved by the County Medical Societies, but their qualifications for membership in these special memberships have not been completely gone over by the Committee. There has been considerable confusion in the past, and there perhaps is more confusion this year because of the change in some of the procedures involved in getting special memberships for some of the members. Previously, each County Society would send a communication to the State Secretary to find out if their member was eligible for one special membership, and the State Secretary would reply and tell the County Secretary or other officer whether that member was eligible or not. It was then up to the County Medical Society to act at a regular meeting, stating that they wanted this particular member's name to be brought up before the House of Delegates to receive special consideration and a special type of membership, and that was in resolution form, in triplicate.

Now there has been some change, and I think there will be some change in the Constitution and By-laws this year, which I hope will specify and perhaps simplify some of the procedures that are involved in obtaining special memberships for members of the State Society.

In the past the confusion existed, and certainly it existed today, in which the Committee did not have at its disposal the proper communications from the County Society officials. Until the exact requirement of the Constitution and By-laws in relation to this particular problem is made known to the County officials, then the work of this Committee is very difficult. We are working under a certain amount of stress here, and we run into four or five telegrams that have come in, in a hurry, asking us to act on a certain member who perhaps has the qualifications for a certain type of membership that is desired, but it is necessary to check his qualifications at the state office. Unless a man is of a certain age and has been in practice over a certain number of years, or unless he conforms with certain other qualifications of membership, certainly the Committee cannot act legally, according to our Constitution and By-laws.

In the past I know that in the hurry of final arrangements to give special memberships to members, resolutions have been written out on prescription pads in triplicate, and all sorts of varieties of stationery hanging around rooms and so forth, and presented to the Committee, and certainly they are not in proper form for their consideration.

We have in our files now perhaps ten or fifteen names which we have not acted upon. I am sure there are other men who have the same questions as this Delegate asked at the present time.

We have all of the names that have been presented in the proper form, and Dr. Foster has made arrangements and has already helped us a lot in checking over the qualifications in Lansing for a lot of these men whose names came in later.

We expect to report tomorrow morning with certain other names whose qualifications we have checked, and our report will be completed at that time.

The Speaker: Thank you, Dr. Lightbody.

Is there any further discussion on the motion to grant special memberships to those whose names were read?

L. W. Gerstner, M.D. (Kalamazoo): Just another suggestion in regard to the rule. I think I am correct in saying that, even though our county was in error also, we are supposed to present these names to the State Society for verification thirty days before

this meeting. I think that is an important rule because that would prevent all this, if I am correct.

THE SPEAKER: May I ask the Secretary of the Society to give us a word on this, so we can take back to our societies the proper information?

SECRETARY FOSTER: Mr. Speaker and Members of the House: There have been releases from time to time, in the Secretary's Letter, in THE JOURNAL, and through all the medians of communication we have, and in the Constitution and By-laws itself, to the effect that in the desire to grant special membership to anyone it is incumbent upon the county medical society thirty days before the meeting to check with the executive office and give us an opportunity to certify to the eligibility or non-eligibility of the doctor in question. When that will have been done, the county medical society, based on that certification, then prepares in triplicate a resolution or a request to this body, that they grant these special memberships.

It is perfectly simple. The certification is to determine, first, the eligibility. Frequently county secretaries say, "We would like to give Dr. Jones Emeritus Membership," and we find in the records in our office that, instead of having practiced the required number of years, he is one, two or three years short, and is therefore not eligible. So the ruling was made several years ago that the request for certification must be made thirty days before the annual meeting, and then after they have cleared and the man is eligible, the county medical society, in triplicate, requests this House to grant the membership, and then it is presented here, sent to the Referenc Committee, and voted on by you.

THE SPEAKER: Thank you, Dr. Foster. Is there any discussion on the motion?

J. J. LIGHTBODY, M.D. (Wayne): There is one name that was omitted—Dr. Benjamin Goodfellow, of Genesee. He was approved by the Committee.

THE SPEAKER: The name of Dr. Benjamin Goodfellow has been added to the list.

Is there any further discussion on the question?

If not, all in favor of granting special membership to those whose names were read say "aye"; opposed, "no." The motion is passed.

The next item on the agenda is the Report of the Reference Committee on Ethics. Is Dr. Donald here?

Dr. Donald, I believe, is in session with his committee and will report tomorrow night.

Before we recess, I should like to state that there were two or three questions asked by the Reference Committee on Reports of The Council. Those questions have been answered by the Chairman of The Council to the Chairman of the Reference Committee, and supplemental report will be rendered to us tomorrow, because many of us may be wondering about the same things.

Dr. Foster, do you have any announcements before we recess?

(Announcements by Secretary Foster, followed by announcements by The Speaker on meetings of the Reference Committees.)

THE SPEAKER: Is there anything further to come before the House? If not, we stand recessed until ten o'clock tomorrow morning.

(The session recessed at 10.25 p.m. to reconvene at at 10:00 a.m. the following day.)

(To Be concluded in December issue)

Postgraduate Courses — 1949

The University of Michigan Medical School

Application of the Basic Sciences to Clinical Medicine, January 3-29. This program will correlate the basic sciences with clinical medicine. Lectures will cover the phases of chemistry, physiology, bacteriology, pathology, and pharmacology which are directly applied in the practice of internal medicine as well as clinical medicine. Daily ward rounds in small groups will offer practical demonstrations with patients and emphasize problems in physical diagnosis. Clinical conferences with the pharmacologist, bacteriologist, and pathologist will further aid in the correlation.

The fee is $100.00. Registration: Room 2040, University Hospital.

* * *

Urology Conference, January 19-20. A two-day postgraduate program in urology and related sciences is being offered by the Postgraduate Department of the University of Michigan under sponsorship of the Detroit Urological Society. The lectures and clinics have been selected to interest the specialists in both practice and basic knowledge of urology.

Registration will be open at 9:00 A.M., January 19, 1949, in the Rackham Building. A limited number of rooms have been made available at the Michigan Union. The fee is $15.00.

* * *

ANNOUNCING A NEW INTRAMURAL POSTGRADUATE COURSE IN CANCER

Beginning Tuesday, January 25, and continuing daily through Friday, January 28, 1949, a course dealing primarily with the four most common cancers, namely, those of the skin, breast, uterus, and rectum, will be offered to qualified practitioners residing in Michigan.

The program will be given in the University Hospital, Ann Arbor, Michigan, and will consist of four general lectures, one on each day of the course, and also four daily sessions in Pathology. The remainder of the day will be given over to clinical sessions.

Enrollment is limited to twenty-four physicians (acceptance in order of receipt of applications). Fee is $25.00.

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Howard H. Cummings, M.D.
Department of Postgraduate Medicine
2040 University Hospital
Ann Arbor, Michigan



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RESEARCH IN THE SERVICE OF MEDICINE

SEARLE

Say you saw it in the Journal of the Michigan State Medical Society

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

NEW HEALTH DEPARTMENT VOTED

People of Lapeer County voted 2,363 to 1,774 to establish a county health department. When this department has been established, local departments will serve seventy-two of the state's eighty-three counties and 94 per cent of the state's population.

CHILD SAFETY CAMPAIGN

The Department is participating in the child safety campaign which is now getting under way throughout the nation.

Sponsored by the United States Children's Bureau, the American Academy of Pediatrics, the National Safety Council and the Metropolitan Life Insurance Company, the campaign is planned to remove accidents from their first place among causes of death among children.

An average of 640 Michigan children lose their lives through accidents—fires, falls, firearms, poisons, drowning, suffocation and traffic—each year.

AID IN PREVENTING ENTERITIS

Health officers and hospital administrators interested in promoting a study of nursery techniques in any hospital in relation to prevention of diarrhea and enteritis may secure assistance by writing to the Michigan Department of Health.

SODIUM CITRATE DISCONTINUED

Because of the availability of gamma globulin for the prevention and modification of measles, the Department has discontinued the distribution of sodium citrate.

STATE EMPLOYES X-RAYED

Approximately 2,000 employes and officials of the State of Michigan were x-rayed by a transportable chest x-ray unit of the Michigan Department of Health during the first two weeks in October. The unit was set up in the Capitol and other state buildings.

In a similar 1947 survey, of 1,900 state officials and employes, twenty abnormal chests and eleven cases of tuberculosis were discovered.

The survey is part of the state-wide tuberculosis case-finding program which is carried on by five mobile chest x-ray units operated by the department.

EYESIGHT HANDICAPS MANY CHILDREN

Poor eyesight handicaps one out of every five Michigan school children, it is indicated by facts revealed in a study conducted by the Department Vision Consultant during the past year.

A study of 33,585 children in nine counties showed that 3,864 had some sight defect. In addition, there were 2,748 children who were under treatment or had undergone treatment for eye conditions. In co-operation with the Michigan Department of Public Instruction, classroom adjustments were recommended for 1,011 of the children.

During the first year of the Department's vision conservation program, the consultant visited twenty-seven counties meeting with school and health people and other organizations interested in developing local vision conservation programs.

The Department has testing instruments, light meters, and motion picture films dealing with vision which can be borrowed by local groups. It also has lists of educational materials dealing with vision. Equipment and materials as well as the services of the consultant are available upon request.

CAUSES OF PREMATURITY STUDIED

To assist in removing prematurity from the leading causes of death in the state, the Department is concentrating on a premature program.

More specific information in the incidence of prematurity is being sought. To facilitate this, a new item, weight at birth has been added to birth certificates. A baby weighing five and a half pounds or less is considered premature.

With an eye to further developing the premature program, Dr. Fanny Kenyon, Associate Director of the Bureau of Maternal and Child Health, is visiting some of the outstanding premature centers in the country—Peoria, Springfield, Chicago and Denver. She will also take a postgraduate course in the medical care of premature babies.

Prematurity took more Michigan babies' lives last year than all other causes, and it was the seventh leading cause of death for all age groups in the state.

WATER WORKS MEN HONORED

John M. Hepler, Director of the Bureau of Engineering of the Department, has been given the George Warren Fuller Memorial Award of the American Water Works Association for distinguished service in the water supply field.

The national award established in 1937 is given each year to one person in each state. Hepler was particularly cited for his encouragement and assistance to water works operators of Michigan and for his work in development of water treatment processes.

Fifty-eight water works people of the state were given the Edward Dunbar Rich Service Award of the Michigan Section of the American Water Works Association. They are men and women who have spent more than 25 years in the water works field.

NEW HOSPITAL CONSTRUCTION PLANNED

Thirteen million dollars worth of new general hospital construction is scheduled for Michigan in the next two

years, according to announcement from the Office of Hospital Survey and Construction.

The construction is made possible under the terms of the Hill-Burton Act which provides that the federal government will grant aid to communities and non-profit organizations up to one-third of the total cost of construction and equipping of new hospitals and additions to existing hospitals.

Manistique was the first Michigan community to open bids for construction. Other cities which have general hospital construction scheduled to get under way in the next 12 to 18 months are: Menominee, Iron Mountain, Hancock, Rogers City, Manistee, Holland, Sturgis, Mt. Clemens, St. Joseph, Benton Harbor, Greenville, Traverse City, Hastings and Frankfort.

The federal government is scheduled to pay $4,346,218 of the cost of construction in these cities.

HOME FIRES ARE FATAL

Six times as many Michigan people die in fires in their own homes as die in public building and hotel fires, records of the Department show.

SANITARIAN TRAINEES REMAIN IN STATE

Three of the twenty-two sanitarians who had field training in Michigan under the Department's Field Training Program have elected to stay in Michigan. A fourth may also take a position here. Others have returned to their respective schools for further academic training.

DEPARTMENT VISITORS

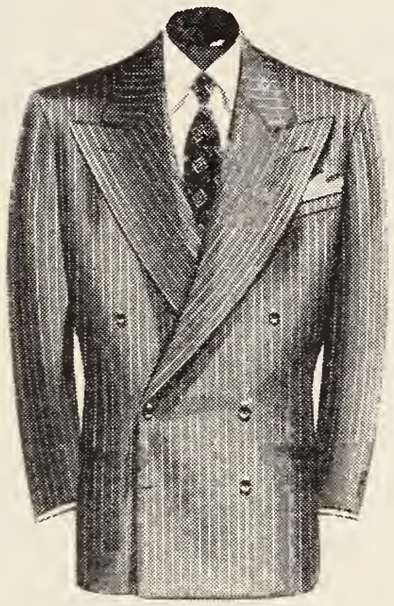
Visitors from China and Switzerland observed the work of the Department during September.

They were Dr. Lin Chih-Ching of the National Chungking University, Chungking, China; and Professor Edmund Grasset, who will head a new school of public health in Geneva, Switzerland.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	September 1948	September 1947
Diphtheria	10	12
Gonorrhea	993	1,057
Lobar pneumonia	52	31
Measles	191	161
Meningococcic meningitis	7	13
Pertussis	155	1,034
Poliomyelitis	249	273
Scarlet fever	126	88
Syphilis	1,048	1,402
Tuberculosis	343	622
Typhoid fever	5	18
Undulant fever	11	28
Smallpox	0	0

The clinical and x-ray pictures of virus pneumonia may at times be duplicated by early acute tuberculosis, and patients diagnosed as having virus infections should not be dismissed until the chest films are entirely clean.—David T. Smith, M.D., *Am. Rev. Tuberc.*, April, 1948.



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ampins for subcutaneous use are now available containing:

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OBSTRUCTIVE JAUNDICE AND HEMOLYTIC ICTERUS

(Continued from Page 1239)

color index .9. It was noted that the red cells appeared normal in size, shape and hemoglobin content.

Comment

This case presents a characteristic picture of familial hemolytic icterus which ultimately showed the expected clinical improvement following splenectomy, as demonstrated by an improved blood picture and clearing of the icterus. An unusual aspect was the development of an acute obstructive jaundice which required priority surgery, with the splenectomy deferred for later performance as an interval procedure.

Summary

1. A case of familial hemolytic icterus is presented in which there existed an obstructive jaundice with cholangitis and a common duct stone.
2. It differs from the usual case in that the obstructive jaundice forced the handling of this aspect of the case as a surgical emergency.
3. After successful surgical relief of the obstructive picture an interval splenectomy was performed for alleviation of the symptoms of the basic condition with good results.

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MICHIGAN STATE MEDICAL SOCIETY

Supplemental Roster 1948

(The following names were certified by County Medical Societies after the Roster had been sent to publishers of THE JOURNAL)

Allegan County
Flinn, Charles C.....Allegan
Rigterink, George H.....Hamilton
Stuch, H. T.....Allegan
Van Ness, J. H.....Allegan

Berrien County
Helkie, W. L.....Three Oaks
Herring, N. A.....Niles
Woodford, Hackley.....Benton Harbor

Calhoun County
Upson, Wilbur O.....Oceanside, Calif.

Eaton County
Engle, Paul H.....Olivet

Genesee County
Ragan, Russell M.....Flint
Reynolds, Arthur J.....Flint

Ingham County
Badgley, W. O.....Lansing
Brubaker, Earl W.....Lansing
Brucker, Karl B.....Lansing
Cook, Raymond J.....Lansing
Cowan, John A.....Charlotte
Darling, L. H.....Lansing
Dean, Carleton.....Lansing
De Vries, C. F.....Lansing
Finch, Russell L.....Lansing
Fortino, S. P.....Lansing
Foust, Earl.....Lansing
Gardner, Cyrus B.....Lansing
Goldner, R. E.....Lansing
Huntley, Fred M.....Lansing
Isbister, J. L.....Lansing
Jones, Francis A.....Lansing
Kent, Edith Hall.....Lansing
Kent, Herbert K.....Lansing
Klunzinger, W. R.....Lansing
Kraft, L. C.....Leslie
Loree, Maurice C.....Lansing
Lucas, T. A.....Lansing
Ludlum, L. C.....Lansing
McIntyre, J. Earl.....Lansing
Meade, W. H.....Lansing
Parker, Earl E.....Leslie
Prall, H. J.....Lansing
Richards, Frank.....Dewitt
Schultz, Arthur E.....East Lansing
Smith, A. V.....Mason
Snell, D. M.....Lansing
Spaulding, Thomas.....Lansing
Spencer, Perry.....Lansing
Toothaker, K. W.....Lansing
Trescott, Robert F.....Lansing
Wiley, Harold W.....Lansing

Kent County
Cuncannan, Edward.....Grand Rapids

Lenawee County
Stark, Emily S.....Adrian

Mecosta-Osceola-Lake County
Peck, Louis K. (E).....Barryton

Marquette-Alger County
Janes, R. Grant.....Pleasant Ridge

Mason County
Hunt, Ivan L.....Scottville

Oceana County
Jensen, Viggo W.....Shelby

Oakland County
Baker, Frederick A.....Pontiac
Burgess, G. L.....Ferndale
Schlecte, Eva L.....Rochester
Wagley, P. V.....Pontiac
Warner, J. F.....Detroit
Weisberg, Wm. W.....Detroit

St. Clair County
Gunderson, Edward P.....St. Clair
Kahn, Oscar B.....Capac

Shiawassee County
Cook, Ernest A.....Owosso

Washtenaw County
Brill, Thomas M.....(M) Ann Arbor
Craig, William R. Jr.....(M) Ann Arbor
Gulde, Andros.....Chelsea
Horne, Stephen F.....(M) Ann Arbor
Maxim, Edward S.....Willow Run
Stocker, Marvin L.....Ypsilanti
Van Duzen, Verne L.....Ypsilanti
Zarafonetis, Chris J. D.....Ann Arbor

Wayne County
Bennett, William E.....Detroit
Brey, Norman.....Detroit
Briggs, William J.....Detroit
Barenholtz, Benjamin.....Detroit
Downes, George O.....Detroit
Delaini, Stella.....Detroit
Hull, Robert P.....Detroit
Jones, Arthur J.....Detroit
Klein, Alfred.....Detroit
Levin, M. M.....Detroit
McDonald, Peter.....Wyandotte
Ohrt, Harold F.....Detroit
Pensler, Leslie.....Detroit
Podolsky, Harold M.....Detroit
Piccone, Louisa.....East Dearborn
Schillinger, Harold K.....Dearborn
Stocker, Harry.....Dearborn
Tremain, Harold.....Detroit
Wittenberg, Samson S.....Detroit



Communication

The Holland, Michigan, Blood Bank has issued the following statement:

Doctors of Medicine have been transferring blood from one human to another for over a century. However, it remained for the large scale emergencies of World War II to demonstrate the full importance of whole blood transfusions as a life-saving measure.

Likewise, the storage of whole blood and plasma for emergency use was practiced before the late war, but the technique for letting, storage, handling and transportation were much improved during the war. This means that sufficient whole blood now can be made available at all times in any community.

Heretofore, blood banks have been maintained only in fairly large centers of population, hospitals, and often at a cost to the patient which was almost prohibitive. This was not the fault of the hospitals or the medical profession, but rather the fault of the method of maintainence.

The American Red Cross in World War II made the American people blood conscious. The people learned that blood meant the quicker end to a costly and brutal war. Now, they are asking why it cannot mean a happier peace. The American Red Cross collected nearly fourteen million pints of whole blood from the American people during the late war. This blood came from the small village as well as the large city. The Citizen of the small community thereby was made "blood conscious." Now he is asking for his "life-saving service" for himself and his neighbor.

To the end, that this "life-saving service" may be made available in a small one-hospital community this manual of instructions is written.

The entire service is maintained by voluntary workers. The plan is initiated and directed by the local physicians. Participating agencies in the maintainence, are the County Medical Society, American Red Cross, County Health Department, County Nurses Association, Hospital, local civic groups, churches, and rural areas.

Thereby, all community groups can participate in the program. Each has its assignment.

The end result is a great community service at a cost in reach of every one.

Blood from the community—for the community—available at all times.

Blood Is Life.

COMMUNITY BLOOD BANK PROGRAM

COUNTY MEDICAL SOCIETY
(Medical Director sets up and runs entire program)

1. Community Hospital	Storage Typing Cross matching	
2. Local Red Cross Chapter	Blood Program Chairman Nurses Aids Gray Ladies Canteen Ladies Motor Corp	Conduct publicity & donor clinics under direction of medical dir.
3. County Nurses Association	Assist physicians at donor clinics	
4. Chuch groups	Assist donor recruitment	
5. County Health Department	Arranges for Kahns and Rh to be run on all donors	
6. Civic groups	Luncheon Clubs Woman's Club Schools P.T.A.	recruit donors
7. Industry	Personnel Dept. Unions	recruit donors
8. Rural	Local Red Cross Chairman Recruit donors	



Fifth CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE

March 1, 2, 3, 4, 1949

PALMER HOUSE • CHICAGO

A scientific program planned to bring information concerning newer developments in all fields of medicine and presented by a group of outstanding speakers.

A wide range of scientific exhibits which promise to be of special interest. Time given for viewing the well displayed technical exhibits. Luncheon round tables where your questions will be answered.

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ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive course in Surgical Technique, two weeks, starting November 29, January 24, February 21.

Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks starting November 8, February 7, March 7.

Surgical Anatomy and Clinical Surgery, two weeks, starting November 22, February 21, March 21.

Surgery of Colon and Rectum, one week, starting March 7, April 18.

Surgical Pathology every two weeks.

GYNECOLOGY—Intensive Course, two weeks, starting February 21, March 21.
Vaginal Approach to Pelvic Surgery, one week, starting February 14.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4.
Personal Course in Gastroscopy, two weeks, starting April 18.

DERMATOLOGY—Formal Course, two weeks, starting April 18. Clinical Course every two weeks.

CYSTOSCOPY—Ten-day Practical Course every two weeks.

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. . . . . NEWS MEDICAL

Russia is many years ahead of us in social legislation.

* * *

H. W. Wiley, M.D., Lansing, acted as Chairman of the Section on Obstetrics and Gynecology on September 22.

The Society's thanks are extended to Dr. Wiley for help in an emergency.

* * *

Michigan Medical Service and United Medical Service of New York City have each passed the millionth mark in subscribers.

And Oscar Ewing says that the voluntary plans are not doing a job!

* * *

Best paragraph of the week was Winston Churchill's, "And even our present standards can be maintained only because we are receiving a large part of our needs from capitalist America, at whose system our socialist rulers never cease jeering."

* * *

E. Isbey, M.D., Detroit, was elected President of the staff of Holy Cross Hospital, Detroit, on September 8. The President-Elect is R. Cushing, M.D., Secretary is E. Zabinski, M.D., the Treasurer is P. Iacobel, M.D., and R. Tenerowicz, M.D., was elected as Honorary President. All are from Detroit.

* * *

The American Academy of General Practice of Michigan was organized at a meeting at Hotel Statler in Detroit on Thursday, September 23. The following officers were elected: M. S. Ballard, M.D., Grand Rapids, President; L. T. Henderson, M.D., Detroit, President-Elect; H. F. Raynor, M.D., Detroit, Secretary-Treasurer.

* * *

"It's Your Life" is a new and different radio health program, endorsed by the AMA Council on Industrial Health, which made its bow on October 18 over station WMAQ, Chicago. This program, presented as a public service by Johnson and Johnson, manufacturers of medical supplies, is being heard Mondays through Fridays at 12:15 p.m. EST.

* * *

Wayne County Medical Society reports 2,275 routine requests for physicians during one month—in the otherwise quiet thirty-one-day period of August, 1948. During this month 169 emergency calls were arranged and 623 calls from the public for miscellaneous information were answered. Incidentally, Detroit and Wayne County list 365 doctors for day and night emergency calls.

* * *

A. E. Schiller, M.D., and *C. E. Umphrey, M.D.,* both of Detroit, addressed the National Affairs Section of the Economic Club of Detroit, in the Book-Cadillac Hotel, Detroit, on October 21. Their subjects were "What are President Truman's Latest Proposals for the Public Health Based Upon the Ewing Report?" and "What Has Been the Experience in England and in Other Countries Which Have Tried Compulsory Health Insurance?"

* * *

"We must teach the public how to measure the health of the community and how to assess the relative importance of physicians' services in community health . . . our only interest should be the presentation of the plain, unvarnished facts to the general public as fairly as we can. The facts are on our side. The medical profession has nothing to fear from the truth."—MAURICE H. FRIEDMAN, M.D., in *Annals of Medical Society, District of Columbia.*

* * *

The United States Chapter of the International College of Surgeons, have a meeting called for St. Louis, Missouri, November 15, 16, 17, 18, 19, and 20, 1949. Louis J. Gariepy, M.D., of Detroit, is the Secretary. The following Michigan doctors are on the program: L. J. Gariepy, Detroit; William J. Cassidy, Detroit; Luther



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Leader, Detroit; Louis J. Hirschman, Detroit, and D. J. Liethauser, Detroit. Hugh W. Brenneman is on the Publicity and Press Committee.

* * *

The Illinois State Medical Society's dues have been raised for 1949 in order that $5.00 may be deposited in the fund of the Benevolence Committee to be used for physicians, their widows or dependent children. The Secretary's Letter states, "This does not constitute charity and is not extended as such. Through the allotment of $5.00 per annum from each member, a trust fund can be developed, the income from which will pay the recipients under the Benevolence Committee's supervision."

* * *

Mount Carmel Mercy Hospital, Detroit, election of staff members for the year 1948-49 resulted in the installation as President of Arch Walls, M.D., Detroit, and Joseph M. Grace, M.D., Detroit as President-Elect. L. J. Gariepy, M.D., Detroit, was elected Chief of the Department of Surgery; Henry L. Smith, M.D., Detroit, Chief of the Department of Medicine; and C. N. Swanson, M.D., Detroit, Chief of the Department of Gynecology and Obstetrics.

* * *

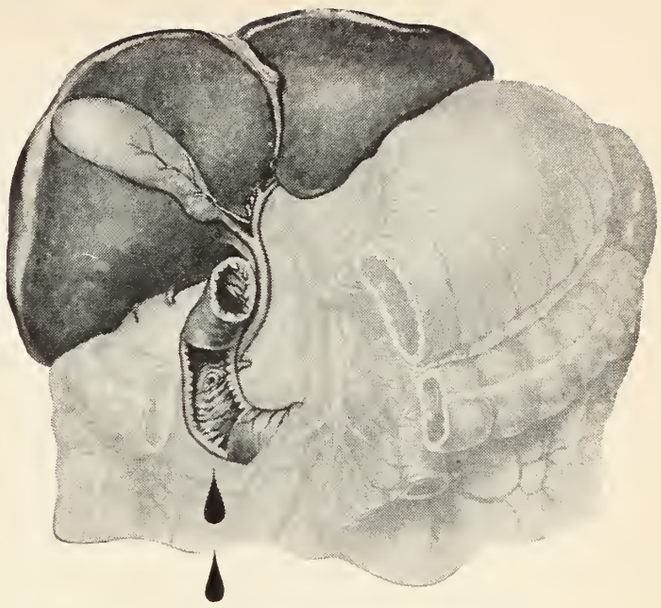
Conditions in England.—"Before I go back to my country with its shilling worth of meat a week, its declining standard of life, its business desperately entangled, please let me tell you, my friends in the United States and in Canada, that the road Great Britain is traveling is the road you should not travel. The experience is not worth while. It is a road which has led to degradation and lowering of our human standards in which you and we believe."—Sir Wm. Y. Darling, M.P., in *Zanesville* (Ohio) *Masterwheel.*

* * *

The Wayne County Medical Society's Mediation Committee—appointed eighteen months ago to analyze and adjust all complaints having to do with the economics of the practice of medicine against members of the Society in Detroit and environs—received only thirty-seven complaints from a population of two and a half million people, in one and one-half years! The chief complaint was over fees, but squawks about house and hospital calls, health examinations, et cetera, also were received. The AMA calls the Wayne County Medical Society's work "solidly good public relations."

* * *

International Medical Assembly.—The Thirty-third year of the International Medical Assembly, a post-graduate school, was held at Cleveland, Ohio, November 9, 10, 11, 12, 1948. Roy D. McClure, M.D., of Detroit, is a member of the Committee on Research and Advancement. Sylvester E. Gould, M.D., Associate Professor of Pathology, Wayne University College of Medicine, gave an address on "Trichinosis." Cyrus G. Sturgis, M.D., Professor of Internal Medicine, Director Simpson Memorial Institute and Chairman of the Department of Internal Medicine, University of Michigan, conducted a Diagnostic Clinic "Illustrating Newer Methods in the Treatment of Hematologic Disorders."



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In discussing the management of chronic cholecystitis without stones, Albrecht states:

"The object of the medical procedure is to assist in draining an infected organ."*

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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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Sabel's Surgical Shoes are carried in pattern and leather matching the Club Foot Shoes so that where required, even in split sizes, they can be fitted to the other foot.

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CADILLAC 3820

The American Academy of General Practice will hold its first Annual Scientific Assembly at the Netherland Plaza Hotel, Cincinnati, March 7-8-9. E. C. Texter, M.D., Detroit, President-Elect of the AAGP advises that 18 outstanding medical features have been selected by the Program Committee, with more to follow.

E. Clarkson Long, M.D., Detroit, is Chairman of the Committee on Exhibits. Approximately 70 displays sponsored by the leading pharmaceutical and equipment manufacturers of the country will feature the technical exhibit. Over 2,000 members and their wives are expected at the AAGP meeting of 1949. No registration fee for members. For hotel accommodations write Committee on Hotels, American Academy of General Practice, Dixie Terminal Building, Cincinnati 2, Ohio.

* * *

The "Health Educator" in the Truman-Ewing socialized medicine plan.—"Snuggled away innocently enough in Ewing's plans are some truly fantastic proposals. There is one calling for 2,800 health educators—one for every 50,000 persons in the country. . . . Under the training program of the Public Health Service, such educators receive an unfortunate indoctrination in philosophy of State medicine. Perhaps they are sent to Ann Arbor to be indoctrinated by Nathan Sinai. Or they may go to the University of North Carolina to hear Dr. Lucy Morgan, daughter of TVA Morgan, expatiate on the wonders of Social Security medicine. Or they may go to Yale. In any event, training, wholly or partly at public expense, includes a liberal education in the advantages of public medical care. Persons so trained are then supposed to spread the gospel in every community where they are sent."—*American Medicine and the Political Scene,* September 10, 1948.

* * *

The U. S. Childrens Bureau has appointed an Advisory Committee on Federal-State Programs for Maternal and Child Health and Crippled Children Services, composed of forty-seven representatives of the producers and consumers of health services for mothers and children. These representatives met in Washington the week of September 20 to advise the Children's Bureau on matters of public policy affecting the protection of better health for mothers and children.

Michigan representatives on this Committee include Kenneth A. Easlick, D.D.S., Professor of Dentistry, University of Michigan, Ann Arbor; Katharine Faville, R.N., Dean, College of Nursing, Wayne University, Detroit; Hugh R. Robins, M.D., Director, Calhoun County Health Department, Marshall; Nathan Sinai, D.P.H., Professor of Public Health, University of Michigan, Ann Arbor and James L. Wilson, M.D., Professor of Pediatrics, University of Michigan, Ann Arbor.

No practitioner of medicine from Michigan was selected for this advisory committee—no *"producer* of health service for mothers and children!"

* * *

The Foster Foundation, a philanthropic organization in the city of Grand Rapids, recently announced the winners in the contest for medical papers published in recognized state and national medical journals. A total of thirty-three papers were submitted dealing with various aspects

of medicine and surgery. They were published prior to January 1, 1948, and were judged by a specially appointed committee from members of the University of Michigan Medical School Faculty. A banquet for all the doctors who submitted papers in this contest is planned for October 28, 1948, at which time all the awards will be made.

The winners were: $250.00 (1) Eaton, R. M.: Pulmonary Edema; $100.00 (2) Veenboer, W. H., and Kooistra, H. P.: Vaginal Hysterectomy with Radical Advancement of the Uterosacral Ligaments for Pelvic Floor Hernioplasty in Cases Showing Third Degree Uterine Prolapse, $100.00 (3) Hill, A. M., and Webber, J. E.: Serum Phosphatase Values in Children Showing Retardation in Osseous Development and Low Metabolic Rates; $50.00 (4) Hodgen, J. T., and Frantz, C. H.: Arrest of Growth of Epiphyses.

The following additional papers received Honorable Mention: McDougal, W. J.: Effect of Parenteral Saline Solution on Wound Healing; Hufford, A. R., and Stonehouse, G. G.: Orientation of the Gastroscope by Roentgenograms; Foshee, J. C.: Fascia Lata Regeneration (Final Report).

* * *

Michigan Medical authors include the following:

Leo J. Croll, M.D., and Maurice Croll, M.D., Detroit, published a paper, "End Results in Retinal Detachment," with many illustrations and fields in *American Journal of Ophthalmology,* September, 1948.

D. P. Hornbogen, M.D., Marquette, published a paper "An Operation for Shortening a Rectus Muscle in *American Journal of Ophthalmology,* for September, 1948.

Parker Heath of Boston, formerly of Detroit, conducted a Clinic on Mikulicz's Disease and Syndrome in *American Journal of Ophthalmology,* August, 1948.

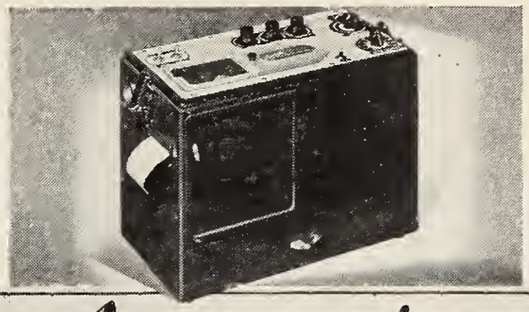
Charles H. Johnston, M.D., of Detroit, had a paper on, "Supportive Procedures," in the *Journal of the Missouri State Society* of October, 1948.

Hiram T. Langston, M.D., of Detroit, published an editorial, "Present Status of Pulmonary Decortication," in *Surgery Gynecology and Obstetrics,* of October, 1948.

Herman Pinkus, M.D., of Detroit, published a paper on, "Lichen Striatus and Lichen Planus Report of a Case of Simultaneous Occurrence, with Discussion of Nomenclature and Mechanics of Linear and Systematized Dermatoses," reprinted from *The Journal of Investigative Dermatology,* July, 1948.

Max K. Newman, M.D., of Detroit, Chief of Section, Physical Medicine and Rehabilitation, Grace Hospital, and Harriet Barbara Jewett, O.T.R., Director of Occupational Therapy Course, Wayne University, Director of Occupational Therapy Department, Grace Hospital, published a paper, "A Co-ordinated Program of Physical Therapy and Occupational Therapy in a General Hospital Physical Rehabilitation Program," in the *Archives of Physical Medicine,* July, 1948.

Louis A. Schwartz, M.D., of Detroit published an article in the **Journal of Public Health Nursing** for September, 1948, entitled "Public Health Nurse in Mental Hygiene."



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CORRELATIVE NEUROANATOMY. By Joseph J. McDonald, M.S., M.Sc.D., M.D., Joseph G. Chusid, A.B., M.D., and Jack Lange, M.S., M.B. Fourth edition, revised. Palo Alto, California: The University Medical Publishers, 1948. Price, $3.00.

A comprehensive manual for the student in gross anatomy, neuroanatomy, neurodiagnosis and neurology which correlates the anatomical and physiological background with the clinical findings of neurological disorders. Included are numerous diagrams which clearly show the distribution and functional components of the cranial, spinal and autonomic nerves, and the essentials of brain and spinal cord localization.

The first part deals with the peripheral nerves, and each major nerve is well illustrated and systematically described. The autonomics are concisely discussed including the physiology and pharmacology of the system.

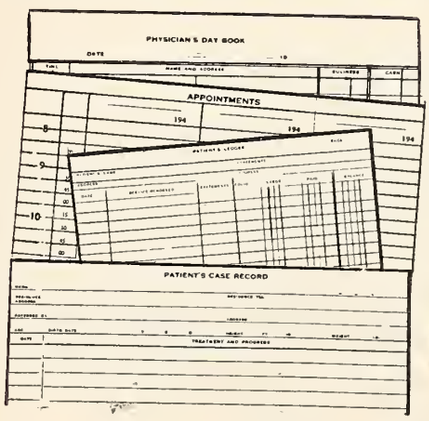
The second section is on neurodiagnosis and includes a discussion of the anatomy, physiology and localization in the brain and spinal cord. The subjects of motion, sensation, reflexes, trophic changes, electrical examination, intracranial pneumography and examination of the cerebrospinal fluid are thoroughly outlined. A discussion of electroencephalography with representative electroencephalograms has been added.

The third section of the book deals with disease and disorders of the central nervous system, and has been completely rewritten and enlarged.

The appendix gives a complete list of neurological signs and syndromes, a brief discussion of muscular dystrophies and atrophies and an outline of the neurological examination.

NUTRITIONAL ANEMIA. Volume I of the Symposia on Nutrition of the Robert Gould Research Foundation, Edited by Arthur Lejwa. Cincinnati: The Robert Gould Research Foundation, Inc., 1947. No charge.

This volume is a collection of papers prepared for the Symposium on Nutritional Anemia, organized by the Robert Gould Research Foundation held in Cincinnati, October 16-18, 1947, under the auspices of the University of Cincinnati. Eleven papers are presented on closely related subjects, such as the Physiological Im-



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plications of the Anemic State, Physiology of Folic Acid, Treatment of Nutritional Anemias with Folic Acid, Megalblastic Anemia in Infancy, Metabolism of Iron and Copper, Studies on the Iron-Binding Capacity of Serum, Iron Metabolism and Hyperchromic Anemia, Hypoferric Anemia of Childhood, Vitamin B Complex and Anemia, and Vitamin C and Anemia. These are good papers, well worth reading and may be had for the asking.

PREOPERATIVE AND POSTOPERATIVE CARE OF SURGICAL PATIENTS. By Hugh C. Ilgenfritz, A.B., M.D., F.A.C.S., former Assistant Professor of Surgery, Louisiana State University School of Medicine, and Visiting Surgeon, Charity Hospital of Louisiana at New Orleans. With a Foreword by Urban Maes, M.D., D.Sc., F.A.C.S., Emeritus Professor of Surgery, Louisiana State University School of Medicine. Illustrated. St. Louis: The C. V. Mosby Company, 1948. Price, $10.00.

This author has presented a systematic study of the treatment of the surgical patient before operation, and the proper preparation and planning of planned care throughout the surgical experience of the patient. Experiences of recent years and the war have changed many procedures, and given a new concept of treatment.

The physiological basis of therapeutic measures is discussed and the complications give minute detail of consideration as to pathogenesis and treatment. Alternative procedures are given and evaluated. The book contains 898 pages, well printed and convenient in size. It is a valuable contribution.

PRACTICE OF ALLERGY. By Morris T. Vaughn, M.D., Richmond, Virginia, and J. Harvey Black, M.D., Dallas, Texas. 1,132 pages; 33 illus. St. Louis: The C. V. Mosby Co., 1948. Price, $15.00.

Those interested in allergy will remember Vaughan's first edition in 1939 of "Practice of Allergy" as one of the best and most complete volumes on that subject. The revision of the first edition by Dr. Harvey Black retains the same style and outline but is brought up to date in line with the advances in this field.

The scope of allergy has grown from case reports of "unusual dramatic cases" to the point where everyone engaged in the practice of medicine recognizes the existence of allergic disease whether he be a specialist or engaged in a busy general practice. For this latter group as well as the specialist this book serves as a valuable reference. It covers the field completely and in a manner easily understandable. It is not presented in an overenthusiastic manner sometimes seen in books in specialized fields.

For the medical student as well as the practitioner the history of allergy is aptly covered as well as the mechanisms and the physiological interpretations of the disease. The chapters on Aerobiology and Pollen Surveys by Oren C. Durham present excellent available reference for checking the incidence of various pollens in all the states and provinces of the United States and Canada. The book also contains information concerning recent studies on vital capacity in a chapter by Doctor James Holman.

Techniques are discussed. The clinician who has become distrustful of the results and accuracies of skin testing for foods in the diagnosis of food allergy will find valuable information in the chapters dealing with the food diary, the elimination diets, the escallator program and the leukopenic index. It is unfortunate that

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some of the newer work in food allergy is not cited, such as the concept of masked food sensitivity, as pointed out by Rinkel. It is also unfortunate that Rinkel's technique of the "individual food test," which differs materially from the leukopenic index of Vaughan, is not mentioned. First, it differs from the leukopenic index insofar as the patient must be prepared by avoiding the food for four days prior to testing. Secondly, in the "individual food test," emphasis is placed, at least in part, on the clinical response after test feeding, whereas the "leukopenic index" relies totally on a laboratory procedure. It is unfortunate that at least some comment was not made regarding Rinkel's contributions.

The book, in spite of these omissions, is one of the few outstanding complete books in the field of allergy and should find a place on the reference shelf of every physician.

RECENT ADVANCES IN OBSTETRICS AND GYNECOLOGY. By Aleck W. Bourne, M.A., M.B., B.Ch. (Ca,b.) F.A.C.S. (Eng.) F.R.C.O.G. Obstetric Surgeon to St. Mary's Hospital; Consulting Surgeon, Samitarian Hospital for Women; Late Examiner University of Cambridge and the Conjoint Board, and Leslie H. Williams, M.D., M.S. Lond. F.R.C.S., (Eng.), F.R.C.O.G.; Obstetric Surgeon to In-Patients, St Mary's Hospital; Consulting Obstertic Surgeon, Queen Charlotte's Hospital. Seventh edition. 85 illus. Philadelphia and Toronto: The Blakiston Company, 1948. Price, $6.00.

In the three years since the last edition, there have been many new developments in the field of obstetrics and gynecology, necessitating the complete rewriting of six chapters. The chapter on Ovarian Tumors is eliminated and a new one on The Anemias of Pregnancy has been substituted. Each chapter takes up its subject matter care-

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fully and concisely, giving the newest understanding and practice, also closing with a workable reference list for further study. The book is compact, not much more than pocket size, and a handy reference.

MICROBIOLOGY AND PATHOLOGY. By Charles F. Carter, B.S., M.D., Instructor in Pathology and Applied Microbiology, Parkland Hospital School of Nursing, Dallas, Texas; Director, Carter's Clinical Laboratory, Dallas, Texas; Consulting Pathologist, St. Louis Southwestern Railway Hospital, Texarkana, Arkansas. 216 text illus.; 25 color plates. Fourth edition. St. Louis: The C. V. Mosby Company, 1948. Price, $5.00.

Like so many other books on scientific subjects, the subject matter of this book has undergone such truly prenominal changes that a new edition was almost imperative. Since the third edition, the science of the sulphonamides has developed, making the older book obsolete. Bacteriological tests and procedures are thoroughly discussed, with the science of microscopy, the study of materials, and their selection. Immunology and the defenses of the body are given due consideration, including the study of hypersensitiveness, and the determination of the sensitizing agent. The filterable viruses and their diseases are studied, and the whole field of pathology, studying the various body systems and tissues, and their diseases. This is a very handy volume, not too voluminous for careful study.

CANCER MANUAL. Standards for the Diagnosis and Treatment of Cancer by the Cancer Committee of the Iowa State Medical Society. Iowa City: The Athens Press, 1948. Price, $1.00.

This volume is similar to the one published by the Cancer Committee of the Michigan State Medical Society. It discusses the general considerations of handling the cancer problem, the incidence, the methods of case finding, and the function of the family doctor in the problem. The study is then handled in separate chapters on the skin, eye, ear, salivary glands, thyroid, lip, larynx, lungs, breast, tongue, mouth and cheek, esophagus, stomach, throughout the whole body and its organs. Radiation therapy is discussed in the last chapter, and the end of the book is devoted to a very well-selected bibliography. It is a worthy study, and gives a timely help to the doctor who comes in contact with cases of suspected cancer.

WAR POLITICS AND INSANITY. In Which the Psychiatrist Looks at the Politician. By C. S. Bluemel, M.A., M.D., F.A.C.P., M.R.C.S. (Eng.) Denver, Colorado: The World Press, Inc., 1948.

The national elections of 1932 threw many Republicans out of office during the great depression, and this author was struck by the number of suicides and attempts at suicide among these men out of a job. What was the matter with politicians as a group? A political leader has greater sociological importance than a doctor or a lawyer, yet nothing comparable is required of him in the way of training or education. What urges a man into the political field? These answers can be given through psychiatry.

This book is a study into the causes of war, the problems of leadership, common disorders of personality, psychiatry in history, democracy in action. A study is made from the psychiatric viewpoint of many personalities —Hitler, Stalin, Mussolini, Napoleon, Johnnie Appleseed, Paul Ehrlich, Oliver Cromwell, and such great social movements as the Crusades, the Red Cross movement, the constitutional state, democracy. How much different

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would have been the history of the world if, after the first World War, Germany had had such leaders as Washington, Jefferson, Monroe, Lincoln, instead of Hitler, Goering, Goebels, Rosenberg and Rippentrop. This book is challenging and thought provoking.

ESSENTIALS OF PATHOLOGY. By Lawrence W. Smith, M.D., F.A.C.P., formerly Professor of Pathology, Temple University School of Medicine, Associate Professor of Pathology, Cornell University Medical School, and Assistant Professor of Pathology, Harvard Medical College; Corresponding Member of the Royal Flemish Medcial Academy of Belgium, and Edwin S. Gault, M.D., F.A.C.P., Associate Professor of Pathology and Bacteriology, Temple University School of Medicine. With a foreword by the late James Ewing, M.D., Memorial Hospital, New York. Third edition. Philadelphia and Toronto: The Blakiston Company, 1948. Price, $12.00.

The almost unbelievable advances in the field of pathology during the past quarter of a century have prompted the new edition to adhere almost exclusively to essentials. There are 740 illustrations in this 764 page book, printed on large pages, two columns to the page. The volume contains two sections, General Pathology, such as retrograde processes, disturbances of circulation, somatic death, necrobiosis, necrosis, calcification, avitaminosis, inflammation, specific bacterial infections, diseases caused by animal parasites, oncology. The second section concerns Systemic Pathology, covering the various systems, circulation, respiration, gastrointestinal, urinary tract, sex organs, nervous system. The illustrations are unusually good, clear, and well selected. A most valuable book for the practitioner and the student.



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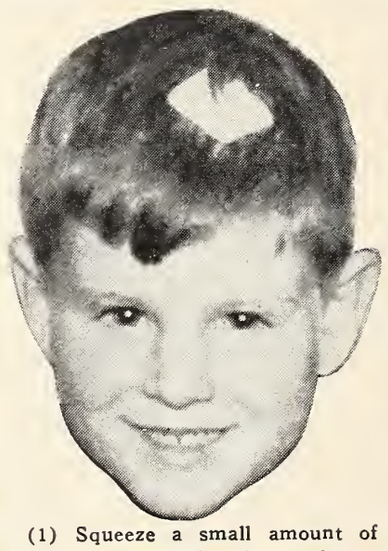
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HIGHLIGHTS OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of October 20, 1948

• Monthly financial reports and bills payable were presented, studied and approved.

• Attendance report on MSMS Annual Sessions indicated an increase of 765 per cent in thirteen sessions, from 1935 to 1948.

• Matters referred to The Council by the 1948 MSMS House of Delegates:

(a) Resolution re consultation of doctors of medicine with practitioners of other healing schools was referred to a special committee composed of J. S. DeTar, M.D., Chairman, W. E. Barstow, M.D., and C. E. Umphrey, M.D.

(b) Creation of national agency for voluntary health service plans. Action was deferred pending probable draft of a plan developed at French Lick convention of Blue Cross-Blue Shield, which plan is to be placed on the agenda of the November Executive Committee meeting.

(c) Remove block in both Basic Science and State Board of Registration in Medicine. This was referred to the Committee of Six, representative of the Michigan State Medical Society, the State Board of Examiners in Basic Sciences and the Michigan State Board of Registration in Medicine.

(d) Increase number of medical graduates in the State. This matter was thoroughly discussed and referred to a committee composed of E. F. Sladek, M.D., Chairman, J. S. DeTar, M.D., L. Fernald Foster, M.D.

• National Foundation for Infantile Paralysis—request for appointment of a Medical Advisory Committee was approved. President Sladek selected the following for the Committee: Mark F. Osterlin, M.D., Traverse City, Chairman, O. O. Beck, M.D., Birmingham, Frank Curtis, M.D., Detroit, Neil R. Moore, M.D., Bay City, and Homer H. Stryker, M.D., Kalamazoo.

• Committee reports were received from Program Committee on 1949 Michigan Postgraduate Clinical Institute; from Michigan Health Council; and from Committee on Basic Science Law Administration.

• The Public Relations Counsel's progress report included up-to-date information on the "Tell Me, Doctor" radio program; on "Lucky Junior," the

(Continued on Page 1316)



Photo by Dale Rooks

THE NEW COUNCIL—MICHIGAN STATE MEDICAL SOCIETY

Front Row, L. to R. P. L. Ledwidge, M.D., Detroit, Immediate Past President; L. Fernald Foster, M.D., Bay City, Secretary; W. E. Barstow, M.D., St. Louis, President-Elect; O. O. Beck, M.D., Birmingham, Chairman of The Council; E. F. Sladek, M.D., Traverse City, President; A. S. Brunk, M.D., Detroit, Treasurer; and J. S. DeTar, M.D., Milan, Speaker of the House.

Second Row, L. to R. W. S. Jones, M.D., Menominee; F. H. Drummond, M.D., Kawkawlin, Chairman Publication Committee; A. H. Miller, M.D., Gladstone; T. E. DeGurse, M.D., Marine City; R. C. Pochert, M.D., Owosso; William Bromme, M.D., Detroit; W. B. Harm, M.D., Detroit; and J. D. Miller, M.D., Grand Rapids, Chairman County Societies Committee.

Third Row, L. to R. E. A. Osius, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo, Vice Chairman of The Council; C. E. Umphrey, M.D., Chairman of Finance Committee; P. A. Riley, M.D., Jackson; D. W. Myers, M.D., Ann Arbor; L. C. Harvie, M.D., Saginaw; E. A. Oakes, M.D., Manistee, and C. A. Paukstis, M.D., Ludington.

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HIGHLIGHTS OF THE COUNCIL MEETING

(Continued from Page 1314)

MSMS motion picture; on Medical Associates; on recent news releases; on sex education transcriptions (in co-operation with Wayne University); and on proposed 1949 Michigan Rural Health Conference.

• The Standing Committees of The Council, as appointed by Chairman O. O. Beck, were approved by the Executive Committee of The Council.

• President Sladek read the personnel of his 1948-49 committees and displayed a map showing the geographical distribution and councilor district spread of his Committee appointments for the year; appointments were approved by the Executive Committee of The Council.

• The monthly reports of the President, the President-Elect, the Editor and the Secretary were approved.

• President Sladek was selected as MSMS representative on the Medical Committee of the Michigan Chapter, American Multiple Sclerosis Society.

• J. F. Harrold, M.D., E. J. Robson, M.D., and J. F. Sander, M.D., all of Lansing, were appointed as MSMS representatives to the Governor's Conference on Youth to be held in Lansing November 12-13.

• Michigan Heart Association Organization Committee. The personnel of this Committee, as appointed by President Sladek, was approved by the Executive Committee of The Council. Additional appointments will be made to the Organization Committee at later dates.

• J. S. DeTar, M.D., Milan, was selected as Michigan's Foremost Family Physician for 1948 and his name was authorized to be submitted to the American Medical Association for its General Practice Gold Medal Award.

• The Executive Committee of The Council approved the formation of a statewide organization of Medical Assistants, provided that MSMS is requested to and does appoint an Advisory Committee to the Michigan Medical Assistants Society.

• United States Children's Bureau Advisory Committee. Inasmuch as no *practicing* doctors of medicine from Michigan have been placed on this Advisory Committee on Federal-State programs for Maternal and Child Health and Crippled Childrens Services, a committee purported to represent the "purveyors of services" to these groups, the Executive Committee of The Council instructed that a letter be dispatched to the FSA requesting that Michigan *practicing* physicians, Doctors of Medicine, be placed on this Advisory Committee.

• The present-day policy on examination of inductees was discussed and information on this subject was authorized to be sent to the Menominee County Medical Society.

• A "Cancer Control Day," to be sponsored by the MSMS Cancer Control Committee et al and to be held in Grand Rapids on Saturday, September 24, 1949, the day following the MSMS Annual Session, was approved by the Executive Committee of The Council.

• Thanks to Dr. and Mrs. Frank Van Schoick, Jackson, for their hospitality in opening their summer home to the members of the Executive Committee of The Council on this occasion were placed upon the minutes.

EXTRACTS FROM THE 1948 MSMS HOUSE OF DELEGATES PROCEEDINGS

1. From the Reference Committee's report on the Annual Reports of The Council:

"The Reference Committee approves the statement on 'Information to the Public.' The Committee believes that the money spent for public relations is wasted unless each and every doctor does his share toward good public relations in his daily contacts with the public."

2. From the Reference Committee's Report on Officers Reports:

"The Committee unanimously commends the Speaker's statements on impractices and on the Michigan Health Council. The Committee urges that all Michigan State Medical Society Delegates co-operate with the MSMS Public Relations Committee and The Council in implementing their recommendations on impractices and on the Health Councils."

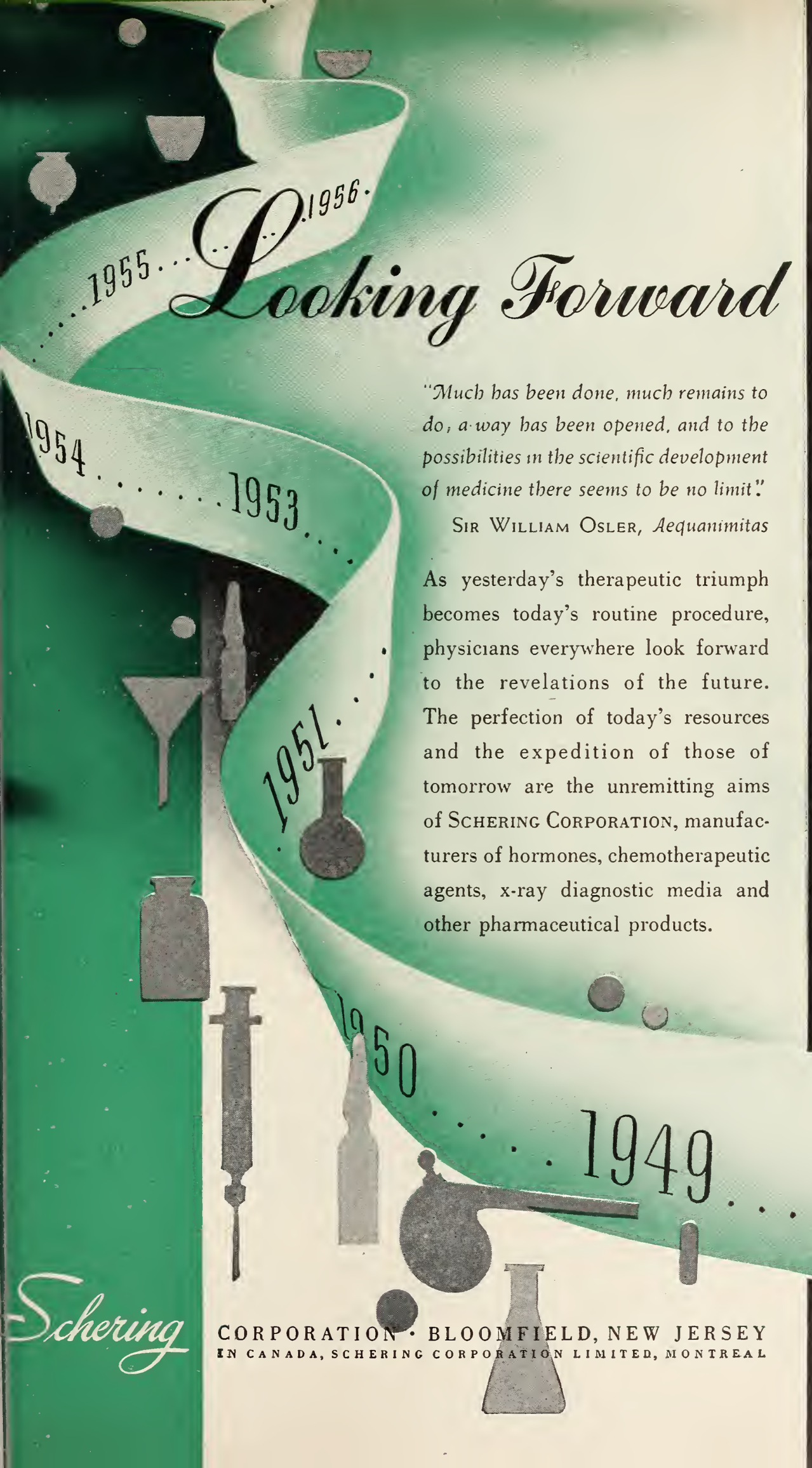
3. Ophthalmology—Substitute motion adopted by 1948 House of Delegates:

"WHEREAS, We propose to continue to conduct the practice of medicine according to the experience and judgment of a responsible medical profession, working from the scientific, sociological, and economic angles according to plans based on experience to increase the distribution of good care,

"WHEREAS, The Michigan State Medical Society is in the habit of looking at its problems squarely, fearlessly, honestly, and by analysis, and

"WHEREAS, After analysis, to approach new methods as scientific men should, by planning and experimentation, knowing that the complicated subject of economics in

(Continued on Page 1434)



SCHERING

"Much has been done, much remains to do; a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

SIR WILLIAM OSLER, *Aequanimitas*

As yesterday's therapeutic triumph becomes today's routine procedure, physicians everywhere look forward to the revelations of the future. The perfection of today's resources and the expedition of those of tomorrow are the unremitting aims of SCHERING CORPORATION, manufacturers of hormones, chemotherapeutic agents, x-ray diagnostic media and other pharmaceutical products.

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IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

Michigan Medical Service

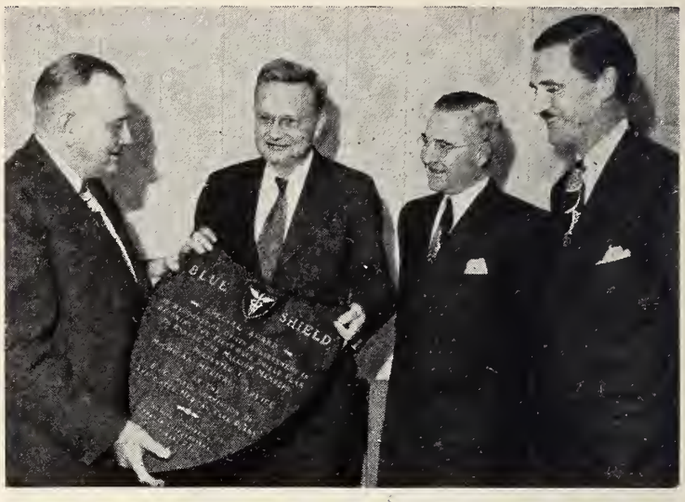
OVER ONE MILLION SUBSCRIBERS!

"One of the solid rocks upon which the entire Blue Shield movement rests," was the description of Michigan Medical Service given by Paul R. Hawley, M.D., Chief Executive Officer of the Blue Cross-Blue Shield Commissions, in presenting a testimonial plaque to this state's medical service organization.

Speaking before the annual convention of the Blue Cross and Blue Shield Plans at French Lick, Indiana, in October, Dr. Hawley awarded the citation to Michigan Medical Service to commemorate its being the first Blue Shield Plan to enroll a million subscribers, a mark which was reached last April.

How many is a million persons? Dr. Hawley pointed out that Michigan Medical Service subscribers now number more than the combat troops used by General Eisenhower in the Normandy invasion and more troops than General MacArthur used in the Philippines.

"This is a great achievement," he said, "but we have come to regard Michigan Medical Service as a plan of great achievements. It is one of the solid rocks upon which the entire Blue Shield movement rests. It is one of the trustworthy anchors that has held Blue Shield steady in stormy weather."



PAUL R. HAWLEY, M.D., Chicago, Chief Executive Officer, Blue Cross-Blue Shield Commissions, on the left, presents R. L. NOVY, M.D., Detroit, President of Michigan Medical Service, with a testimonial plaque, marking the achievement of the enrollment of a million subscribers by Michigan Medical Service. Looking on are L. HOWARD SCHRIVER, M.D., Cincinnati, President of Associated Medical Care Plans and JAY C. KETCHUM, Detroit, Executive Vice President, Michigan Medical Service.

Michigan Teacher Honored

In presenting the plaque to R. L. Novy, M.D., President of Michigan Medical Service, who accepted the citation on behalf of the organization, Dr. Hawley made eloquent reference to Dr. Novy's father, one of Michigan's celebrated teachers of medicine.

Introducing Dr. Novy as "the distinguished son of an illustrious father," Dr. Hawley declared:

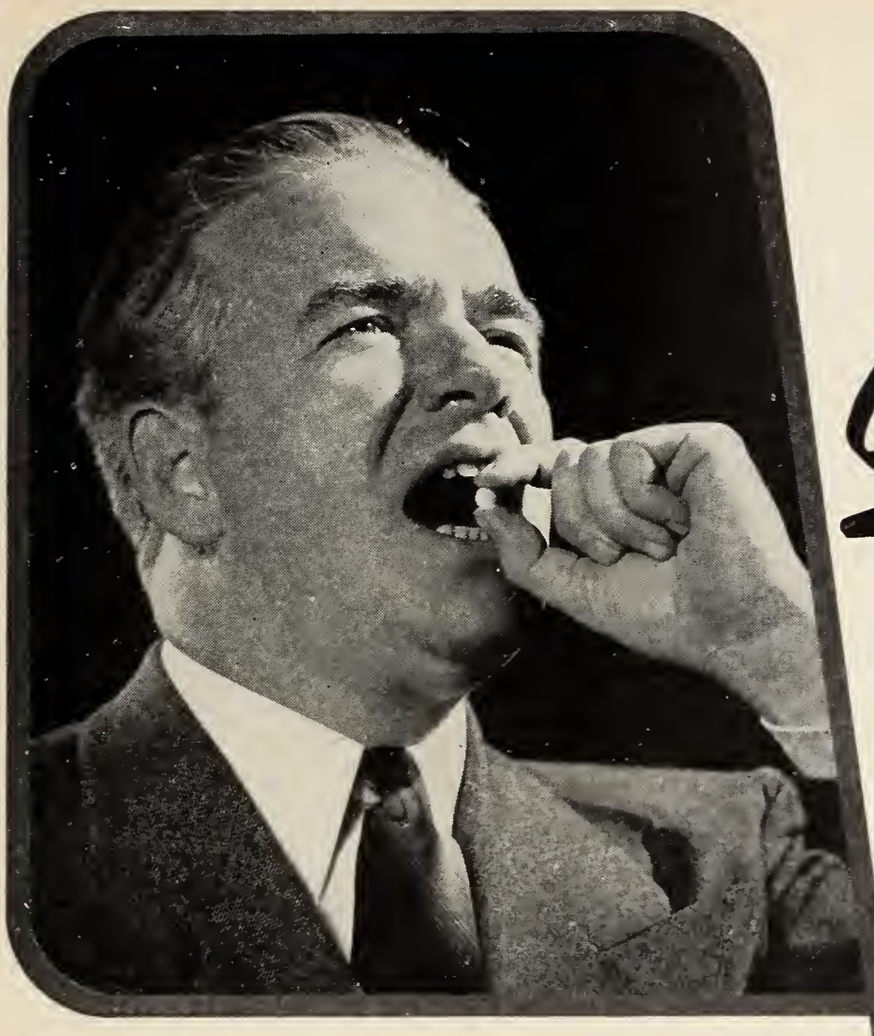
"I take added pleasure in presenting the President of Michigan Medical Service who will accept this plaque. I was a student of medicine in the early days of the entry of science into medicine. Among the teachers of medicine of that day there were a few giants who towered above the others. Schools of medicine were distinguished by the names of these leaders, rather than by the general measure of excellence of their curricula. Prominent among the giants of my student days was Novy of Michigan, whose name will be forever linked to man's knowledge of the anaerobic bacteria. I am happy to learn that he is still with us and in good health."

President Novy Praises Profession

Praising the medical profession of Michigan for its leadership in creating and sponsoring a voluntary medical care plan that has deservedly attracted the attention of medical men throughout the country, Dr. Novy declared in accepting the citation:

"This is an achievement which has come about by the combined efforts of the medical profession, of Michigan Hospital Service, our Blue Cross Plan, and of the staff of Michigan Medical Service."

Officials of Michigan Hospital Service and Michigan Medical Service attending the meeting who were introduced by Dr. Novy were E. D. Barnett, M.D., President, and William S. McNary, Executive Vice President of Michigan Hospital Service; Jay C. Ketchum, Executive Vice President, Gordon Goodrich, Assistant Director, and John Castellucci, Director of the Veterans Program of Michigan Medical Service.



Oral MERCURIAL DIURESIS

Although mercurial diuretics are most active on parenteral injection, oral administration of Salyrgan-Theophylline tablets is usually quite satisfactory. The method is of distinct value when injections are impracticable, as well as when the frequency of injections is to be reduced. Average dose: 5 tablets after breakfast once a week, or 1 tablet three or four times daily on two successive days of the week.



SALYRGAN®-THEOPHYLLINE

***Brand* of Mersalyl and Theophylline**

TABLETS

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Also for injection—ampuls of 1 cc. and 2 cc.

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Cancer Comment

THE ANSWER TO CRITICAL LAYMEN

At many meetings of laymen, where the control of cancer is considered, two questions invariably arise very early in the discussion. One of these has to do with the unwillingness of some physicians to make a medical examination to discover or rule out cancer in an apparently well individual. The other question is whether the general practitioner can recognize cancer when making the examination. Such criticism and doubt on the part of lay individuals may occasionally be justified but in the main are entirely unwarranted and based on lack of understanding of the cancer problem.

Regarding the first of these questions it undoubtedly is true that some physicians, for reasons best known to themselves, brush aside a patient's request for examination with the remark: "You look well, you have no symptoms; forget about cancer and come back if or when you feel ill." Such an attitude is damaging to the physician and to the entire medical profession. Certainly the healthy person who wants to remain well and who is concerned enough with health to consult a physician before he becomes ill, is entitled to as much consideration as the patient who ignores medical educational efforts until in an advanced stage of disease before he seeks medical assistance.

The explanation put forth by such physicians is that requests for cancer detection examinations often come during busy office hours when responsibility to sick patients does not permit of adequate time being devoted to such an examination. In a measure this may be a legitimate excuse but one which can be overcome by making the examinations at a mutually convenient time. With advance appointments, many such examinations can be worked in during office hours as the physicians of Hillsdale County are amply demonstrating in carrying out the "Hillsdale Plan for Tumor Detection." The physicians of that county are averaging 100 examinations per month during office hours.

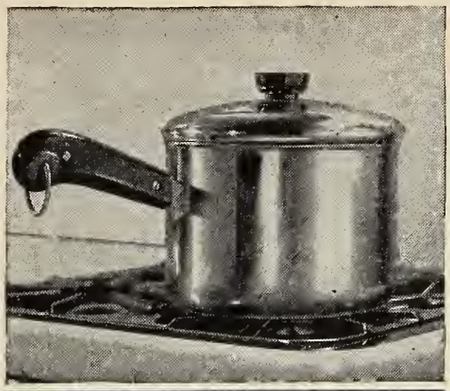
The physician who considers every patient asking questions about health or disease as a neurotic is making a serious mistake. Too few physicians, busy with their day-by-day problems of medical care, realize the extent to which the intelligent public has become informed about health problems including cancer. Some of this information should be labeled "misinformation" or "inadequate" and of no value to the cause of health education. However, much of it is sound and its full value to the community will depend on the part played by the physician in interpreting it to his community.

Physicians everywhere should remember that the public is constantly being told to have a periodic examination to find cancer in early and curable stages. Fifteen cancer detection centers are operating throughout the State of Michigan to furnish these examinations. While they represent a step in the right direction, these centers make demands on a physician's time which could be employed to better purpose if these examinations were made in his own office. (e.g. every doctor's office a cancer detection unit.) Physicians should remember that the public interest in cancer is such that more and better service is being demanded.

The second problem mentioned above is tied in closely with the one just discussed. Many laymen interpret the lack of a physician's interest in making examinations as an effort to conceal his inability to recognize cancer. This impression has also been fostered—probably unintentionally—by some of the lay educational effort stressing the difficulties underlying the diagnosis and proper treatment of certain cancers. This assumption that the family physician cannot diagnose cancer has led to the impression that a much more worthwhile examination can be given in a detection center than in a physician's own office. The detection center atmosphere seems to lend ability to the physician which he does not appear to possess within the confines of his private office. The mere fact that a physician leaves his office to enter a building across the street—the location of the cancer detection center—in no way increases his diagnostic ability. He *can* diagnose cancer and he *can do it* in his own office. Of equal importance is the fact that, by permitting the physician to render this service in his office, these examinations *can* be offered to countless more patients.

Cancer detection centers are making valuable contributions to the control of cancer. However, their chief value lies in the demonstrations they give to the medical profession and the public that cancer can be and is being found in early and curable stages by the examination of apparently well individuals. The physical limitations on these centers preclude their being the answer to the physical examination problem in any community. *This answer can come only by making every physician's office a cancer detection center.*

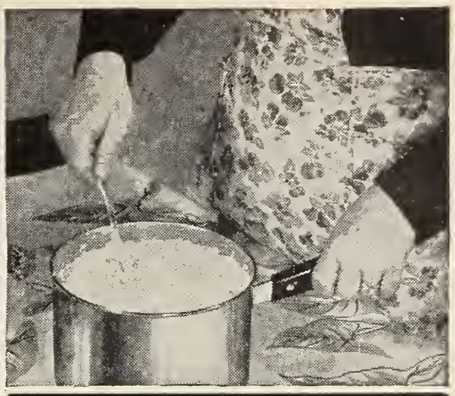
The Cancer Control Committee urges all Michigan physicians to study their local cancer problems, and to aid in their solution.



1. Boil the water and cool to luke-warm



2. Float measured powder on top of the water



3. Mix with a large spoon or fork

SIMILAC FEEDINGS ARE Easy TO PREPARE

It takes only 30 seconds to induce solution *if the powder is floated on top of the water.* Lukewarm, boiled water is desirable.

No need to mix several ingredients—hence the possibility of errors in measurement is greatly reduced.

The ratios of fat, sugar, and protein, *and the zero curd tension,* remain constant regardless of concentration . . . Therefore, no gastrointestinal disturbance will normally occur, should the mother err occasionally in counting the number of measures of Similac powder.

The level tablespoon measure in each can eliminates the possibility of underfeeding or overfeeding due to varying sizes of "tablespoons."

Result: Similac reduces dietary disturbances traceable to mothers' errors in preparation of the formula

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Political Medicine

TRUMAN'S PROGRAM

1. Repeal of the Taft-Hartley act.

2. Expansion of social security coverage with benefits at least 50 per cent higher.

3. Enactment of a national program embracing compulsory health insurance.

4. Passage of the controversial civil rights program, the advocacy of which cost him four southern states.

5. Farm price supports and other agricultural legislation.

SCHOOL TEXTBOOKS

It will be recalled that not long ago many government agencies, such as the United States Public Health Service, were placed under the Federal Security Administration. Henceforth, all policies of any of these agencies must be cleared through the Federal Security Administrator before publicity can be given. Because of serious differences of opinion, Mr. Studebaker, long time head of the Department of Education, resigned. Portions of textbooks were read to illustrate the infiltration of the ideas of socialized medicine into the school books that are studied by junior high school students. For instance, in a text entitled, "We Are the Government," you may read this statement: "We are a democracy like Switzerland, Liberia and the U.S.S.R." Even arithmetic books have been rewritten so that questions pertaining to apples have been changed to problems on hospital expenses, medical care, et cetera. From a ninth grade arithmetic text were cited examples of problems pertaining to the average income of a physician in contrast to the income of persons in other walks of life, of the high cost of medical care to the average citizen. Ninth graders in public schools of America today are computing the percentage of the working man's total income that goes into the pockets of physicians, using as a basis the statistics that the Federal Security Administration chooses to give them.—Editorial, *The Journal of the Kansas Medical Society,* page 426, October, 1948.

TWO WIGS AND LOTS OF TEETH

"Aneurin ("Nye") Bevan, Britain's Health Minister, was a bit embarrassed last week by the public's enthusiasm for government-financed doctoring. He announced: 'It seems that an extraordinary proportion of the population has bad sight. . . . The health service will fail unless the people use it intelligently, sparingly and prudently.' "

"Oysters & Champagne.—How were the British faring with the National Health Service Act, now almost four months old?

"Some patients were running doctors ragged with petty requests. ("I always use Carter's Little Liver Pills. Please can I have a chit so that I can get them free?") A few diehard doctors, still hoping that the act would be a bust, were blandly prescribing champaigne, oysters, whiskey and rum for their patients—at government expense. Some patients were unreasonable. One physician, forced to cancel his evening office hours because of a difficult, ten-hour delivery, was greeted at his surgery next morning by four threatening hoodlums; he was now a servant of the people, they told him, and he had no right to be away during regular working hours. Some doctors were unpleasant. One, called five miles on a case, berated and lectured the parents of a sick child: "This is a fine thing, all this way in my car on the free service."

"The British (about 95 per cent have signed up) were taking advantage of their chance to get medical care and let the government pay the doctor's bill. A check in Birmingham showed that 97 per cent of the people tested actually needed glasses, and manufacturers of frames are two months behind in their orders. Two-thirds of Britain's dentists have signed up under the act; many are swamped with drill-and-forceps work on the notoriously bad British teeth.

"The act has created its own legends. A puzzle still unsolved by the Ministry of Health: the case of the dentist who pulled two of his own teeth, and sent in a claim for payment to himself. Last week* a butcher in Dudley, Worcestershire, asked for three pairs of eyeglasses: one for reading, one for looking at far-off things, one for chopping meat. He got them. In Cambridge, an elderly

(Continued on Page 1324)

*Also last week the act paid for delivery of its first quadruplets.



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Tempting, natural source of complete protein



6 varieties:
Beef, lamb, pork, veal, liver, heart

The things some patients on soft, smooth diets have to eat! It's no wonder appetites lag.

To perk up patients' interest in foods, many doctors now prescribe specially prepared Swift's Strained Meats when soft foods are indicated in a high-protein, low-residue diet. They help two ways. *One*, Swift's Strained Meats taste so good. Few patients can turn down real meat goodness. *Two*, an excellent source of B vitamins, Swift's Strained Meats help restore patients' natural appetite for all foods.

Originally prepared for infant feeding, Swift's Strained Meats are soft, smooth (may easily be used in tube-feeding), slightly salted—cooked to retain all their delicious meat flavor. Six kinds for variety: beef, lamb, pork, veal, liver, heart. Each one 100% meat, they provide an excellent, palatable source of complete, high-quality proteins and hemapoietic iron. These meats make available *simultaneously* all known essential amino acids . . . for optimum protein synthesis. Convenient — Swift's Strained Meats are ready to heat and serve.

The makers of Swift's Strained Meats invite you to send for your copy of "The Importance of Protein Foods in Health and Disease"—a physician's handbook of protein feeding, written by a doctor. Send to:

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For patients who can take foods of less fine consistency —Swift's Diced Meats offer tender morsels of nutritious meat with tempting flavors patients appreciate.



TWO WIGS AND LOTS OF TEETH

(Continued from Page 1322)

woman, bald since the age of six, asked for a wig. Ruled S. W. Davis, the pensions officer: "She will be provided with two wigs, as one occasionally has to be cleaned."

"Pounds and Pence.—What is it all going to cost? Britain is now paying general practitioners a total of £45,000,000 ($180,000,000) a year. The prewar total income of G.P.s: £28,000,000 ($112,000,000). But general practitioners are only part of John Bull's medical bill. Meanwhile, the Health Ministry and those who oppose socialized medicine are busy hurling statistics at each other. The British Dental Association claims that the plan is costing the government seven times the estimated cost for dentistry. Not so, says Bevan: the estimated £7,000,000 ($28,000,000) will nicely cover the first nine months.

"Many doctors who vainly fought the act through the British Medical Association (*Time,* March 1) remain unconvinced. The Labor Government was smart, grumbles the B.M.A. unofficially, in starting the service in July, when sickness rates are lowest: just wait until winter epidemics start jamming the doctors' already crowded offices."—*Time,* November 1, 1948.

NATIONAL HEALTH SERVICE

At the time of the April plebiscite the Council of the British Medical Association issued a document to every member of the profession setting out the changes which the Minister proposed to make in the National Health Service Act in response to the profession's representations. In this document (*Supplement,* April 24, p. 105) it was reported that the universal basic salary would be abandoned and that the Minister intended to limit it to principals during the first three years of practice, with an option to all other principals. Where basic salary was agreed, capitation remuneration would be reduced by one-seventh.

The Minister further agreed to discuss with the profession the conditions and methods of opting, so as to meet the Association's points that basic salary should be paid only where there was need and, except in such circumstances, should not provide a means of opting for higher remuneration per patient.

The fixed annual payments of £300 are credited to the recipients as a first charge on the local pool allocated to each executive council. This means that wherever a basic salary is paid to a practitioner with less than 2,200 public patients on his list an additional payment is being made to such a practitioner by his colleagues in the area.

After further discussions with the Ministry the regulations relating to the grant of basic salary were amended to provide that the local executive council, after consultation with the local medical committee, must decide on every application whether there was reasonable justification for a basic salary.—*British Medical Journal,* Oct. 2, 1948.

THE OREGON CASE

UNITED STATES OF AMERICA, Plaintiff

SUMMONS

Oregon State Medical Society, Oregon Physicians Service, and eight listed County medical societies and eight individual physicians.

There follows the complaint, jurisdiction and venue, defendants, definitions, nature of trade and commerce, constituting thirty paragraphs.

We now quote

V. OFFENSES CHARGED

31. Beginning on or about January 1, 1936, and continuing thereafter up to and including the date of filing this complaint, the defendants have attempted to, and have been engaged in a combination and conspiracy to, restrain and monopolize interstate trade and commerce in the business of selling and furnishing prepaid medical care in the state of Oregon and in other states, in violation of Sections 1 and 2 of the Sherman Act (15 U.S.C., Sections 1, 2). Defendants threaten to continue such offenses and will continue them unless the relief hereinafter prayed for in this complaint is granted.

32. The conspiracy has consisted of a continuing agreement and concert of action among the defendants, the substantial terms of which have been that defendants agree:

(a) To monopolize and attempt to monopolize prepaid medical care business in the State of Oregon and between the State of Oregon and other states.

(b) To limit the scope of medical care to be provided by prepaid medical care plans in the State of Oregon.

(c) To prevent, hinder, and obstruct prepaid medical care organizations other than those sponsored by defendants from continuing to engage in or from engaging in the business of selling and furnishing prepaid medical care in Oregon and in other states.

(d) To restrain residents of Oregon and other states from entering into or continuing under prepaid medical care plans not sponsored or supported by the defendants.

(e) To prevent doctors from co-operating in prepaid medical care plans not sponsored or approved by defendants.

(f) To restrict the use of hospital facilities by doctors co-operating in prepaid medical care plans other than those sponsored or approved by defendants.

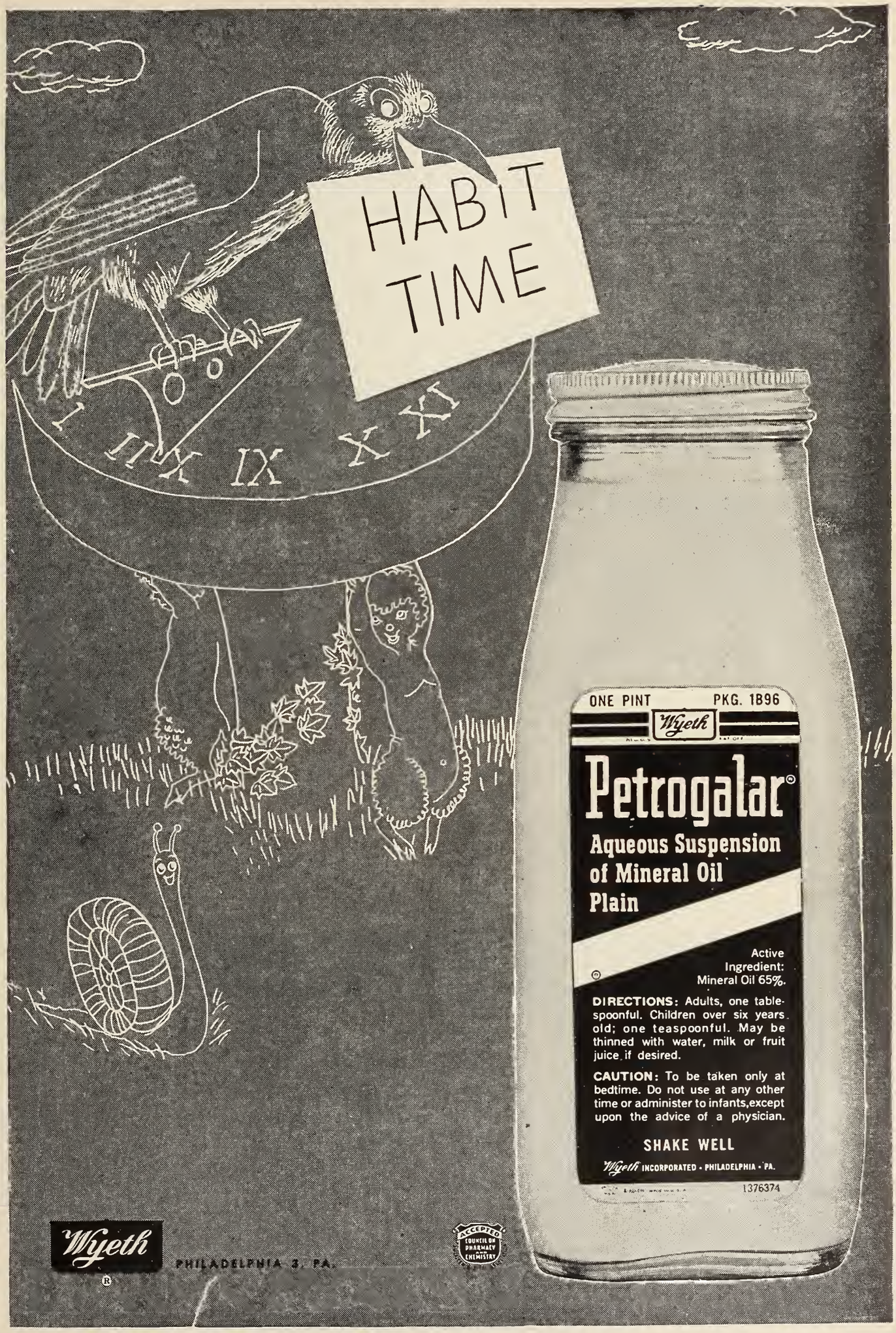
(g) To prevent Oregon hospitals from allowing their facilities to be used by doctors and patients associated with prepaid medical care plans other than those sponsored or approved by defendants.

33. The combination and conspiracy herein above described and the intended restraints which have resulted therefrom have been effectuated in the following manner and by the following means:

(a) Defendants have hindered and obstructed prepaid medical care organizations in their attempts to procure and retain qualified doctors to co-operate with them.

(b) Defendants have expelled, threatened, and incited the expulsion from medical societies of doctors co-operat-

(Continued on Page 1326)


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Mineral Oil 65%.
DIRECTIONS: Adults, one tablespoonful. Children over six years old; one teaspoonful. May be thinned with water, milk or fruit juice if desired.
CAUTION: To be taken only at bedtime. Do not use at any other time or administer to infants, except upon the advice of a physician.
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THE OREGON CASE

(Continued from Page 1324)

ing in prepaid medical care plans other than those sponsored or approved by the defendants.

(c) Defendants have formed and promoted their own prepaid medical care plans with the intent to drive out, hinder, and obstruct other commercial medical care plans operating in the state of Oregon.

(d) Defendants have interfered with commercial prepaid medical care organizations other than those sponsored or approved by them in obtaining hospital facilities for their members.

(e) Defendants have refused to treat patients and have caused others to refuse to treat patients who are members of a prepaid medical care plan not endorsed by defendants unless the patient pays cash.

(f) Defendants have refused and encouraged other doctors to refuse to give patients who are members of a prepaid medical care plan not endorsed by defendants itemized statements that will enable the patient to be reimbursed under the plan to which he has subscribed.

(g) Defendants have refused to consult or assist and have encouraged others not to consult or assist doctors who treat members on a prepaid medical care plan not endorsed by them.

(h) Defendants have spread false propaganda among doctors, hospitals, and the general public for the purpose of discrediting any prepaid medical care plans not endorsed by them.

(i) Defendants have agreed among themselves and with others not to compete with each other for prepaid medical care business or with other similar organizations approved by or affiliated with them.

(j) Defendants have succeeded in making hospital facilities in Oregon available only to members of defendant Oregon Medical Society and its component county medical societies, and have restricted and excluded other qualified doctors co-operating in prepaid medical plans other than those sponsored or approved by defendants from access to such facilities.

34. Each of the individual defendants has been active individually and as an officer or member of defendant associations or corporations in the violations herein alleged.

VI. EFFECTS OF VIOLATIONS

35. The following effects, among others, have resulted from the violations aforesaid.

(a) Prepaid medical care organizations other than those sponsored by the defendants have been prevented and hindered in entering into or expanding their business in Oregon. The business of such organizations outside the State of Oregon has been impeded and their ability to do business outside Oregon has been impaired.

(b) The public in and out of Oregon has been deprived of a fair and free opportunity to acquire prepaid medical care insurance from organizations competing with one another in a free market.

(c) Members of the public in and out of Oregon have been deprived of medical care, which, save for the restraints herein described, would have been afforded them.

(d) Business concerns in and out of Oregon have been deprived of the opportunity to obtain prepaid medical insurance for their employes in an unrestrained market, and their business within and outside the State of Oregon has been adversely affected thereby.

(e) Doctors have been deprived of an opportunity to practice medicine in Oregon on terms of their own choosing, pursuant to the laws of Oregon.

(f) Doctors in Oregon and outside of Oregon have been denied the use of hospital facilities in Oregon.

(g) Hospitals in Oregon have been denied the privilege of making their facilities available to doctors and members of the public.

(h) The market for the sale and distribution of medicines, drugs, medical supplies, and medical equipment has been unduly restricted.

VII. PRAYER

Wherefore plaintiff prays:

(1) That pursuant to Section 12 of the Clayton Act, an order be made and entered requiring such of the defendants as are not residing within this district to be brought before this Court in this proceeding as parties defendant, and directing the Marshals of the District in which they severally are inhabitants, or may be found, to serve summons upon them;

(2) That the combinations and conspiracies in restraint of interstate trade and commerce, together with the attempts to monopolize, conspiracy to monopolize, and monopolization of the same, hereinbefore described, be declared to be illegal and violative of the Sherman Act;

(3) That defendants be perpetually enjoined from further engaging in or carrying out said restraints and conspiracy, from doing any act in furtherance thereof, and from engaging in any similar conspiracy or course of conduct;

(4) That defendant medical societies be perpetually enjoined from refusing to take into their membership, and from expelling or threatening to expel from their membership, any doctor because of his co-operation in medical care plans other than those sponsored or approved by the defendants;

(5) That defendant medical societies, upon application or request therefor by any such doctor, shall reinstate as a member in good standing any doctor who has been expelled from membership because of his co-operation in a medical care plan other than those sponsored or approved by the defendants;

(6) That defendants be perpetually enjoined from persuading or inducing or attempting to persuade or induce hospitals to discriminate in the use of their facilities against doctors or patients co-operating or associated with medical care plans other than those sponsored or approved by defendants;

(7) That defendants be perpetually enjoined from persuading or inducing, or attempting to persuade or induce doctors not to co-operate in medical care plans other than those sponsored by the defendants;

(8) That the defendants be perpetually enjoined from suggesting, advocating, or agreeing that doctors should refuse to treat patients who are associated with medical care plans other than those sponsored or approved by the defendants; or to discriminate against said patients with respect to fees charged for medical services; or discriminate against said patients by requiring them to pay cash for medical services; or refuse to supply itemized statements to said patients showing the medical services rendered and the fees charged therefor;

(9) That defendants be perpetually enjoined from the publication or dissemination of false or disparaging publicity concerning medical care plans other than those sponsored or approved by the defendants;

(10) That defendants be perpetually enjoined from advocating, inducing, or agreeing that doctors who are

(Continued on Page 1422)



Further evidence of the safety of Benzedrine Sulfate therapy

More data, showing that Benzedrine Sulfate, in proper dosage, produced no toxic effects, have lately been published in a study by Caveness.[1]

He gave the drug for 14 consecutive weeks to 23 unselected hospital patients whose ages *averaged 65 years.* Daily dosages over the period ranged from 5 to 30 mg. The author observes:

"... no significant changes were noted in the cardiovascular, urinary, hematopoietic, or respiratory systems..."

From this study, it would appear that Benzedrine Sulfate may be safely used in the treatment of depression in the aged.

1. New York State J. Med. 47:1003

Benzedrine* Sulfate tablets • elixir

(*racemic amphetamine sulfate, S.K.F.*)

one of the fundamental drugs in medicine

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PR in Practice

Lawmakers Convene January 2

The next session of the Michigan State Legislature will officially open January 2, 1949. Once again the members of the Michigan State Medical Society must be on the alert to see that the best interests of the people are served. Among the subjects that will be of interest to the medical profession during the coming year will be the reimbursable cost formula for hospitals, the practical nurse licensure law, the Hospital Act for mentally diseased persons, the proposed Vocational Rehabilitation Bill, and the proposed amendments to the Social Welfare Act, et cetera.

PR and Secretaries Conference Slated for January 9

The Public Relations and Secretaries Conference will be held Sunday, January 9, at the Book-Cadillac Hotel, Detroit. The conference will be attended by members of the MSMS Public Relations Committee, County Medical Society Public Relations Committee Chairman, and County Secretaries. Approximately 200 are expected to attend.

Medical Associates Brochure Warmly Received

Distribution of the Medical Associates brochure is well under way. Copies have been sent to the American Medical Association for distribution to other state and major county medical societies. It has also been sent to hospitals and schools throughout Michigan. Many requests for this booklet received by the MSMS executive offices have been filled. All of the comments on the brochure received to date have been highly complimentary, and the newspapers of the state have given the program excellent publicity.

"Lucky Junior" Gains National Recognition

The MSMS motion picture "Lucky Junior" has been shown in over 100 Michigan communities to date, has been scheduled for showing in 250 theaters, and will ultimately be presented in 400 theaters throughout this state. Its reception has been uniformly excellent. Letters have been sent to doctors inquiring when the picture will be shown in their vicinity, and publicity has been given by special news releases to newspapers in the locality where "Lucky Junior" is shown.

Outstanding nation-wide publicity has also been received on this picture with stories being carried in more than 300 educational journals as well as in trade magazines of the motion picture industry. Additional publicity has been carried in PR publications and in general letters to medical leaders distributed by the American Medical Association.

Sex Education Transcriptions Near Completion

Dramatized transcriptions of the MSMS sex education scripts are being developed by Wayne University. Half of these platters are scheduled for completion by January 1 and the remaining half by February 1. By following this schedule it will be possible to introduce the series in the Lansing public schools for the second semester preparatory to general statewide distribution next fall.

Magazine Article Lauds MSMS Rheumatic Fever Campaign

Birt Darling of the *Lansing State Journal,* in cooperation with the MSMS PR office, prepared an article on Michigan's campaign against rheumatic fever which was published in the November issue of *Science Illustrated* magazine. This story, which has been commented upon throughout the country, has evoked much interest in the MSMS's Rheumatic Fever Control program.

Detroit Pharmaceutical Firm Sponsors "Tell Me Doctor"

The J. F. Hartz Company, a Detroit pharmaceutical firm, has contracted to sponsor the "Tell Me Doctor" program over CKLW, Detroit, for a year's time. The radio time alone will represent an investment of $10,000 by Hartz.

Four Michigan Representatives Attend AMA PR Conference

Four representatives from the Michigan State Medical Society attended the American Medical Association Public Relations Conference in St. Louis, Missouri, November 27, including W. E. Barstow, M.D., St. Louis, Michigan, President-Elect; J. S. DeTar, M.D., Milan, Speaker; Wilfrid Haughey, M.D., Battle Creek, Editor; and Hugh W. Brenneman, Public Relations Counsel. The delegates, following a welcoming address by George F. Lull, M.D., AMA Secretary, participated in a "Problem Clinic" and a question and answer period dealing with the PR aspects of organized medicine.

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Rheumatic Fever and the School Child

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THE SCHOOL occupies a unique position in relation to rheumatic fever control. Rheumatic fever causes more deaths than any other disease in children of school age. A first attack usually occurs in children at the age when they are in the first or second grade and recurrences are most common up to the age when children are leaving high school. The insidious onset of so many cases during the school years suggests that teachers and others in daily contact with school children should be aware of early signs and symptoms which may mean acute rheumatic fever.

The periodic school health examination when done hastily without removal of clothing may miss children with rheumatic heart disease. On the other hand, children may be labeled with the diagnosis of a rheumatic heart because a heart murmur was wrongly interpreted. This serves to emphasize the opportunities as well as the difficulties of discovering rheumatic fever and rheumatic heart disease in school children.

The problem of what to do about rheumatic fever through the schools is an integral part of what should be done about the health of all school children. The following recommendations, while pointed towards case-finding and health supervision of the rheumatic child, will, if applied, lead to better health service for all school children.

Improvement of the School Medical Examination

The periodic school medical examination should be improved:

1. By obtaining a health history of the child from the parent and the teacher, if possible, at the time of the child's examination.
2. By being performed without haste and with the child disrobed.
3. By the employment of physicians trained in pediatrics, if possible. Where this is not feasible, arrangements should be made for giving physicians who make school medical examinations additional clinical training in normal child growth and development as well as in children's medical problems including rheumatic fever and heart disease.
4. By allowing time for the physicians to plan with the nurse and parent for medical attention. The examination is then more likely to be of greater aid in getting medical care for school children who need it.

The following activities of the nurse should be to see that the children in need of medical attention are referred to physicians and that every effort is made to have needed care given. Special health and welfare resources in the community should, if necessary, be brought to the attention of the family and the child's physician.

Daily Observation of Children with Special Reference to Rheumatic Fever

Nurses and teachers should be more alert to substandard health in all school children. School absence due to illness or vague disorders, if investigated, may disclose early cases of rheumatic fever. In order to make use of the school's daily contact with the child, there should be daily observation of pupils for signs and symptoms suggestive of

substandard health. Among these signs and conditions which should bring children to the attention of the teacher or parent are:

1. Failure to gain weight
2. Pallor
3. Fatigue
4. Frequent colds and sore throats
5. Tonsil and adenoid operations (because it may indicate previous sore throats)
6. Scarlet fever or any known streptococcus infection
7. Unexplained nosebleeds
8. Unexplained fever
9. Poor appetite
10. Pains in arms, legs, and joints
11. Unusual restlessness, irritability or twitching or jerky motions
12. History of previous rheumatic fever
13. Behavior and personality changes
14. Decreasing accomplishments in school by a child who previously has done well

Children reported by the teacher as showing evidence of substandard health should be medically reviewed by the school nurse or physician, to select children who need further medical investigation. A personal interview by the school physician or nurse with parents either in school or through a home visit is recommended, to emphasize the need for further medical attention for the child through the physician of the family's choice.

Schools have tended to place too much emphasis on the finding of a heart murmur in the child. This has resulted many times in needlessly restricting the child's physical activities.

Relatively few rheumatic children attending regular school in the intervals between attacks need to have their physical activity restricted. In a group of 1,000* rheumatic children seen ten years after they first came under observation, 783 were alive and, of these, more than 80 per cent were able to lead normal active lives except in competitive sports. More than half were able to engage in competitive sports.

Preparation of Teachers in Health Guidance

Teachers should know more about children's health problems, including rheumatic fever. Not only should they be able to recognize children with signs and symptoms of substandard health, but also they should realize the importance of protecting children, especially the rheumatic child, from respiratory infections. Children with early signs of upper respiratory infections should be encouraged to stay home. Health education is especially important for the rheumatic child because the chronic nature of the disease requires, as in tuberculosis, that the susceptible individual learn the special importance of good hygiene. Preparation in health guidance should be given both to teachers in training and to teachers in service.

Rheumatic Fever Diagnostic Service

Because of the difficulty of diagnosing rheumatic fever and rheumatic heart disease, and especially the important point of determining whether or not the process is active, special diagnostic facilities should be available to all physicians, including school physicians, who may advise parents concerning care of children with possible, potential, or definite rheumatic heart disease. Diagnostic facilities should have the approval of local medical societies. The consulting specialist in rheumatic fever should have electrocardiographic, fluoroscopic, and other necessary laboratory facilities. Every effort should be made to bring this diagnostic service to the attention of physicians who take care of school children. A complete report of the specialist's examination should be sent to all physicians concerned with the care of the child.

The purpose of this service is not only to diagnose rheumatic fever and rheumatic heart disease and to make recommendations as to the health and educational services needed by the child, but also to screen out those children who have heart murmurs but who do not have organic heart disease. It is also useful in regard to placement and removal of children in special schools and classes for the handicapped.

Co-operation with Community Health and Welfare Agencies

Adequate health services for school children call for close working relationships between medical, public health, social welfare, and educational authorities. The school can improve its services to children by utilizing, at every opportunity, community resources—for example, the use of the clinical teachers of a local medical school to give courses to school physicians, the use of laboratory and clinic services of community hospitals for diagnostic and consultation service; the provision of home or hospital education for children who are bedridden; communication with welfare authorities concerning inadequacies in the home environ-

*Jones, T. D., and Bland, E. F.: Rheumatic fever and heart disease; completed ten-year observations on 1,000 patients. Tr. A. Am. Physicians, 57:265-270, 1942.

ment. These services should be made available to all, but without waste of professional services and of public funds. Close co-operation between the physician, family, school, and other community health and welfare resources is essential.

Summary

The school gives an unusual opportunity to attack rheumatic fever. Certain improvements in school health services are needed to make the best use of this opportunity. These recommendations will not only be a better approach to rheumatic fever but to other health problems of children. The alertness of teachers and school nurses can bring to medical attention children with signs and symptoms suggestive of rheumatic fever whose condition might otherwise be overlooked. It is also an opportunity through periodic medical examinations to discover unrecognized damage to the heart and keep under medical supervision known cases of the disease and to make family studies of rheumatic children. It is an opportunity to teach the principles of healthful living to children who have the disease or who are susceptible.

To aid school health authorities to develop a more rational approach in the control of this disease, it is proposed that (1) the school medical examination be improved to aid in more accurate recognition and supervision of rheumatic children, (2) more emphasis be placed on referral by teachers and nurses of pupils believed to be below par for medical review, (3) less emphasis be placed on restricting the physical activity of rheumatic children and more attention given to daily observation of pupils for signs or conditions suggestive of rheumatic fever, (4) there be available to school health services and the practitioners diagnostic and consultation services to establish diagnosis, (5) these services be developed in co-operation with, and by utilization of, existing medical and public health resources in the community.

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BLOOD SUGAR AND ANGINA

Patients with angina pectoris do not tolerate a low blood sugar level; hence it is important not to overtreat diabetes. It is better for such patients to spill some sugar in their urine than to run the risk of too low a blood sugar level by seeking perfection in diabetic management either by too strict a diet or too much insulin.—Treatment of Heart Disease by William A. Brams, M.D.

Diagnostic Aids in Rheumatic Fever

By Charles A. R. Connor, M.D.
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RHEUMATIC FEVER, although a very common disease in childhood and one responsible for more deaths in this period of life than any other disease, is often difficult to diagnose. No uniform diagnostic criteria have been established.

Rheumatic heart disease is easier to recognize and definite criteria have been established and accepted.[2] There are, however, an appreciable number of children and young adults with abnormal cardiac signs or symptoms in whom a diagnosis of heart disease is uncertain. They are classified as Possible Heart Disease. If such individuals have had a recent attack of rheumatic fever they are then classified as Potential and Possible Heart Disease.

The diagnosis of acute rheumatic fever and rheumatic heart disease are two separate problems, even though there is good evidence to show that the heart is invariably affected during the acute stage of the disease. In a considerable number, one-half to one-third, the lesion in the heart will either heal completely or the residual will be of such a microscopic nature as to be of no clinical significance.

The manifestations of rheumatic fever vary in different age groups. The diagnosis is most difficult in early childhood because of the high incidence of carditis and of vague and bizarre joint and muscle sypmptoms. In early adult life that diagnosis is simpler due to the occurrence of the typical migratory polyarthritis. This is particularly true in the northern half of this country.

When the stage of active rheumatic infection subsides, there may be a latent stage of activity indeterminable by present clinical and laboratory tests. It is not uncommon to have definite signs of rheumatic heart disease appear during this period.

Certain minimum diagnostic facilities and equipment are essential. These include a quiet room with an examining table, a modest laboratory with a technician capable of performing complete blood counts and erythrocyte sedimentation rates, x-ray equipment, preferably a fluoroscope,

and an electrocardiograph. The value of each of these facilities varies with the stage of rheumatic fever. The training and experience of the physician using these tools is obviously the *sine qua non* of any case-finding method.

In any suspected case of rheumatic fever the diagnosis, especially in children, will often depend upon finding evidence of carditis. Carditis is the first of five major manifestations of rheumatic fever in the diagnostic criteria suggested by Jones. Carditis can be diagnosed if the patient develops: cardiac enlargement; significant heart murmurs; pericarditis; or congestive heart failure. Certain electrocardiographic changes in the presence of other manifestations of the disease are also helpful in verifying its presence.

In addition to carditis, other major manifestations are arthralgia; chorea; subcutaneous nodules; and a verified history of previous rheumatic fever. All of these manifestations require less in the way of additional diagnostic equipment than carditis, as they are largely determined by the history and physical examination.

Seven minor manifestations of rheumatic fever are: fever; abdominal pain; precordial pain, erythema marginatum; epistaxis; pulmonary changes; and certain abnormal laboratory findings.

A combination of two major manifestations, or of one major and two minor manifestations would place the diagnosis of rheumatic fever on reasonably safe grounds according to Jones. The weakest combination of these manifestations to warrant a diagnosis of rheumatic fever would be arthralgia, fever and some abnormal laboratory finding usually hematologic.

It is evident that a diagnosis of heart disease—carditis during the active phase of rheumatic fever, or chronic valvular heart disease, indicating a previous attack of the disease—are of prime importance as both are major manifestations of the disease.

An enlarged heart is a diseased heart. Often this single and most important feature of a cardiac examination can be determined by inspection or by palpation of the chest wall. Sometimes an x-ray examination is necessary. Fluoroscopy, utilizing the frontal, right and left oblique views, plus visualization of the esophagus with barium is by and large the most valuable diagnostic aid. Progressive cardiac enlargement either as a whole or limited to certain chambers indicates active carditis. There is often difficulty in applying this diagnostic aid in the case of patients who are acutely ill.

In chronic rheumatic heart disease, the fluoroscopic study is the most important supplement to the physical examination. It is true that organic valvular heart disease, such as mitral stenosis or aortic insufficiency, can be present without any detectable enlargement of any chamber of the heart. The diagnosis of such valvular defects can be made satisfactorily on physical examination. In this regard the use of certain kinds of stethoscopes is helpful, as the Bowles type for high pitched murmurs like the characteristic murmur of aortic insufficiency and the bell-type for low pitched murmur of mitral stenosis. Certain special procedures for eliciting murmurs are equally important. The murmur of aortic insufficiency is best heard with a relatively slow heart rate, with the breath held in expiration and with the patient erect or bent forward. It is loudest in the third or fourth interspace at the left border of the sternum. The characteristic low-pitched diastolic rumble of mitral stenosis is localized at the cardiac apex. It is almost always louder when the patient is lying on his back or left side, especially after sufficient exercise to increase the heart rate to 100 or more per minute.

Much emphasis has been placed on the diagnostic value of the electrocardiogram. In the inactive stage of rheumatic fever and in chronic rheumatic heart disease it is of limited value.

In the active phase of rheumatic fever or in the cases in whom a suspicion of this disease exists electrocardiograms should be taken. Since a single electrocardiogram may show no abnormality, or may be only suggestive, it is desirable to obtain serial tracings at regular intervals. In recent years an unfortunate tendency has arisen to overread electrocardiographic tracings placing unwarranted significance on minor changes in the auricular or ventricular complexes of the record. A detailed analysis of the patterns that may be considered significant is not possible, but for the most part they are changes in the final ventricular deflections, prolongation of the auriculoventricular conduction time, or changes in rhythm. Prolongation of the electrical systole (Q-T interval) has been regarded as a sensitive index of active cardiac infection by some workers. This conclusion, however, is questioned by many.

Laboratory procedures such as blood counts and the sedimentation rate of the erythrocytes are usually helpful in determining the presence of an

active infection. Jones has classified them as minor manifestations since they are not specific for rheumatic fever. They are more pertinent in evaluating the presence of active rheumatic infection in a known case than as a diagnostic aid. The presence of a normal blood count and a normal sedimentation rate does not exclude the diagnosis of rheumatic fever. Normal sedimentation rates are not unusual in patients with severe carditis. In the inactive stage of rheumatic fever such tests are of no value.

Many other laboratory tests both clinical and immunologic have been proposed as an aid in the diagnosis of rheumatic fever. Some are misused, as the antistreptolysin values. A high titer merely indicates an infection with a hemolytic streptococcus in the immediate past. It may be of interest in following the course of the acute stage of the disease, but it is of limited value in the diagnosis. Numerous other tests have been proposed as substitutes for the sedimentation rate, but none of them are specific for rheumatic fever.

Summary

1. The diagnosis of rheumatic fever is often a difficult and time-consuming procedure by virtue of the fact that there is no specific clinical or laboratory test.

2. Accurate diagnosis requires training and experience. It is particularly difficult in cases which have their onset in early childhood. It this age period joint symptoms are often bizarre, and mild cardiac signs and symptoms may dominate the clinical picture. In the adolcscent period the typical migratory polyarthritis syndrome is the commonest clinical manifestation and the diagnosis is easier.

3. Minimum diagnostic facilities are laboratory studies of the blood; x-ray, preferably fluoroscopy, and an electrocardiograph. All have certain limitations which have been discussed.

References

1. Jones, T. Duckett: The diagnosis of rheumatic fever, J.A.M.A. 126:481, 1944.
2. New York Heart Association: Nomenclature and Criteria for Diagnosis of Diseases of the Heart. 4th Edition. New York Heart Association, 1939.

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Eggs of fish and other eggs laid in the sea must be produced in enormous numbers if enough are to survive; one oyster sheds around 30,000,000 eggs in a single season. —*Science News Letter,* November 6, 1948.

Report of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction

American Heart Association

By Irving S. Wright, M.D., Charles D. Marple, M.D., Dorothy Fahs Beck, Ph.D.
New York, N. Y.



I. S. Wright, M.D.

THE POSSIBILITY of preventing the extension of coronary thromboses and the development of mural thrombi in the presence of myocardial infarction by the use of anticoagulants was suggested by Solandt, Nassim and Best[4,5] in 1938. These investigators were able to prevent the development of both coronary thrombi and of intracardiac mural thrombi under conditions in which such thrombi are usually produced experimentally in animals, by the use of the anticoagulant, heparin. Their observations were not applied to man on any significant scale because of the difficulties and the risk felt to be inherent in the use of heparin clinically. In the years 1945 and 1946, Wright,[6,7] Nichol and Page,[2] and Peters, Guyther and Brambel[3] reported encouraging results following the use of the anticoagulant, dicumarol, in the treatment of coronary thrombosis with myocardial infarction in man. These reports were perliminary in nature since only small numbers of cases were reported. However, the uniformly favorable results appeared to justify a more extensive study of the use of anticoagulants in the treatment of coronary thrombosis.

Accordingly, in the spring of 1946, the Board of Directors of the American Heart Association authorized the formation of the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction. This committee is composed of internists with special interest in cardiovascular diseases associated with the sixteen hospitals which have contribut-

This study, a progress report on the statistical analysis of the first 800 cases studied by this committee, has been supported by grants from the U. S. Public Health Service.
Presented at the Eighty-Third Annual Session of the Michigan State Medical Society, Detroit, September 22, 1948.

ed cases to this study. Workers in several additional institutions have participated in an advisory or consulting capacity. The participating hospitals and the responsible investigators are as follows:

Participating Hospitals

Bellevue Hospital, New York.....John E. Deitrick, M.D.
Beth Israel Hospital, Boston..Herrman L. Blumgart, M.D.
Bronx Veterans Hospital.....Louis A. Kapp, M.D.
Cincinnati General Hospital.....Johnson McGuire, M.D.
Helen Glueck, M.D.
Cleveland City Hospital.....Roy W. Scott, M.D.
Henry Ford Hospital, Detroit.....F. Janney Smith, M.D.
Jackson Memorial Hospital, Miami.....
.....E. Sterling Nichol, M.D.
Lakeside Hospital, Cleveland....Joseph Hayman, Jr. M.D.
Massachusetts General Hospital.....
.....Howard B. Sprague, M.D.
Michael Reese Hospital, Chicago.....Louis N. Katz, M.D.
Mount Zion Hospital, San Francisco.....
.....John J. Sampson, M.D.
Pennsylvania Hospital, Philadelphia.....
.....Joseph V. Vander Veer, M.D.
Peter Bent Brigham Hospital.....Samuel A. Levine, M.D.
Rhode Island Hospital, Providence..Frank B. Cutts, M.D.
San Francisco County Hospital.....John J. Sampson, M.D.
The New York Hospital.....Irving S. Wright, M.D.
Harold J. Stewart, M.D.

Consultants

Ralph S. Overman, Ph.D.....Nelson W. Barker, M.D.
Charles E. Brambel, Ph.D.....Grace Goldsmith, M.D.

Central Laboratory

Irving S. Wright, M.D.....*Chairman of Study*
Charles D. Marple, M.D.....*Co-ordinator*
Dorothy F. Beck, Ph.D.....*Statistician*

Each investigator has been assisted by a team of residents, fellows and associates from his staff. Full credit must be accorded each of these workers whose wholehearted co-operation has been indispensable to the success of this study. It is a pleasure to report that one thousand cases with coronary occlusion and myocardial infarction have been studied under the conditions of this investigation.

Plan of the Study

Slightly fewer than one-half of these one thousand cases have been treated by conventional methods of therapy alone. The others have been treated with anticoagulants in addition to convention methods. A record of each case has been prepared in detail on master forms by the responsible investigator and his associates and forwarded to the Central Office of the committee at The New York Hospital. The master forms are being subjected to intensive statistical analysis and a definitive report on the 1,000 cases will be prepared as promptly as the analysis will permit. The present report includes data obtained from analysis of the first 800 cases reported to the Central Laboratory. Although it is possible that the addition of the last 200 cases, and other later revisions, may change the figures somewhat, it is unlikely that the conclusions will be altered significantly since the relationship of the control and treated groups as to deaths and thromboembolic complications has remained relatively stable as the sample has increased in size.

Three hundred and sixty-eight patients admitted to the participating services on *even* days received conventional therapy and constitute "the control group." Four hundred and thirty-two patients admitted on *odd* days received anticoagulants in addition to conventional therapy and constitute "the treated group."

The principles used as guides in the administration of dicumarol and heparin were as follows:

"(a) Heparin may be given for the first 48 hours or more if desired.

(b) Prothrombin determinations are to be done each day and no dicumarol should ever be ordered unless the morning prothrombin report is available.

(c) Dicumarol 200-300 mg. daily should be given until the prothrombin time is 30 seconds.

(d) Dicumarol 50 to 100 mg. daily should be given if the prothrombin time is between 30 and 35 seconds.

(e) Dicumarol is withheld if the prothrombin time is 35 seconds or more. Then, no drug is given until the prothrombin time is again down to 30 seconds or less, after which the drug is again given cautiously in 100 mg. doses.

(f) The Link-Shapiro technique, using undiluted whole plasma, or the Quick method is to be used for determining the prothrombin clotting time and it is suggested that the Link-Shapiro method using 12.5 per cent diluted plasma be employed as an additional check or safeguard. All prothrombin times are given in terms of the Link-Shapiro (undiluted) method.

(g) Unless contraindications arise, the dicumarol therapy is to be continued in the chosen cases over a minimum period of 30 days, preferably 30 days after the last thromboembolic episode.

(h) In instances of hemorrhagic manifestations, the use of synthetic vitamin K preparations in doses of 60-75 mg. and transfusions of fresh whole blood (may be citrated) are recommended."*

A comparison of the patients in the "control" group with those in the "treated" group shows a

*From the instructions issued to each participating team—slightly modified.

striking similarity in regards to age, history of previous infarction and estimated severity of the present attack. The average age of the control group of males was 58.9 years; that of the treated group, 57.2 years. For the females the average age of the control group was 64.1 years, and of the treated group, 64.6 years. In this series of 800 cases, the average for females was approximately 6.4 years older than that for the males.

Analyzing the two groups for a history of one or more previous infarctions, it was found that 24 per cent of the control group and 22 per cent of the treated group had had one or more previous infarctions.

An estimate of the severity of the attack was made for each patient at the time of diagnosis and recorded as mild, moderate or severe. Twenty-three per cent of the control group and 30 per cent of the treated group were classified as having severe attacks. Although this classification is admittedly arbitrary, the results suggest that the treated group contains a somewhat greater proportion of severely ill patients. The control and treated groups were also closely similar when the medical histories of cardiovascular diseases and the locations of their original infarcts were compared.

Eighty-eight per cent of patients in the control group received no anticoagulant, but twelve per cent did receive some anticoagulant therapy, often for short periods only. Anticoagulants were administered to patients in the control group following the development of a thromboembolic complication in three cases out of five, and in the remaining cases because of pressure on the part of the family or a private physician* or miscellaneous reasons. Of the treated group, 81 per cent received dicumarol only, while 14 per cent received dicumarol and some heparin. In three per cent of the "treated cases" no anticoagulants were given because of concurrent renal or hepatic disease or because of hemorrhagic conditions, and 2 per cent received no anticoagulant because of miscellaneous errors.

In the computation of the rates upon which all charts are based, small and conservative corrections were made in order to simplify the presentation. In the control group the rates are corrected for exceptions to the "no anticoagulant" rule. Rates as shown are those it is estimated would have occurred if no case in the control group had received any anticoagulant. They differ only slightly from the data as actually reported and are believed to present a truer picture of rates without anticoagulants. In the treated group the rates are corrected for erroneous omissions of anticoagulants. There is evidence that with more intensive and inclusive anticoagulant therapy, the rates for death and complications in the treated group would have been lower than those shown. No correction was made for those patients from whom anticoagulants were withheld because of specific contraindications. These omissions are considered to be disadvantages inherent to this type of therapy.* In both groups all rates for thromboembolic complications and hemorrhagic manifestations, as stated in this interim report, refer to conditions diagnosed clinically. Statistics based on autopsy findings are not yet available, but are being analyzed at this time.

Comparison of the death rates in the control group and in the group who received anticoagulant therapy, shows that 24 per cent of the control patients died, whereas 15 per cent of the treated patients died. Thus, somewhat more than one-third of the individuals who would have died without anticoagulant therapy survived the specific attack under consideration when anticoagulants were given. This difference is statistically significant.** Further examination indicates that the greatest improvement was achieved in patients who had suffered one or more thromboembolic complications prior to death. Such deaths occurred in roughly 10 per cent of the control cases, but in only three per cent of the treated cases. Death not preceded by a clinically recognized thromboembolic complication occurred in approximately 14 per cent in the controls as against 12 per cent in the treated group. As previously anticipated, anticoagulants reduced the death rate largely by reducing the incidence of those thromboembolic complications which, directly or indirectly, result in death.

*This factor became intensified as the study progressed.

*These corrections were made by assuming that if anticoagulants had been completely withheld from all control cases receiving anticoagulants they would have developed at least as many further complications and would have died at least at the same rate as did control cases of comparable age who received the anticoagulants at any time under approximately comparable circumstances. If actual rates for subgroups among these patients for whom exceptions were made did not already exceed these estimates, the estimates were substituted for the actual data for these particular subgroups. An appropriate modification of this correction procedure was applied in the case of the treated group and for hemorrhagic manifestations in both groups. The resulting corrected figures are portrayed graphically and referred to in the text without reference to the corrections or to the exceptions in treatment. *The corrections for exceptions proved to be small and sometimes were completely without effect on the rates. They do not alter at any point the basic differences between the groups from which conclusions are drawn.*

**The term statistically significant is used throughout the text to mean that the chances that two random samples from the same population would yield on the basis of chance alone differences as great as those observed and in the same direction are less than one in one hundred. In most instances the chances of obtaining these differences in two samples from the same universe are in fact very much less than one in one hundred—in the case of thromboembolic complications, less than one in a thousand.

The death rates by week of illness, were highest during the first two weeks, but were still considerable during the third and fourth week. For each period the death rate for the control patients was found to be significantly greater than that for the treated group. These figures indicate that anticoagulant therapy, if not used before, should be begun even as late as the second or third week after a myocardial infarction has occurred—or later if complications have developed, and, secondly, that, to give maximal protection, anticoagulant treatment should be continued for at least four weeks after the last thromboembolic episode.

The greatest benefits in the reduction of mortality are in patients 60 years or older. These statistics show that the therapeutic effect of anticoagulants is sufficiently important that they should be used in the older age groups. Hemorrhagic complications have been so few and so mild throughout the entire study and the benefits of treatment of the older age group are so pronounced that we do not hesitate to prescribe anticoagulants to older patients. It should be recognized however that older patients have a higher incidence of unrelated complications and that careful consideration of such factors in mandatory. While the crude death rates for patients under fifty-nine in both the treated and the control group, did not show a significant difference, the incidence of thromboembolic complications is high in these age groups, and the treated cases show a much lower incidence of thromboembolic complications. Such thromboembolic complications may not only be serious incidents in themselves, but they may result in such serious permanent disabilities as hemiplegia (following cerebral emboli), chronic venous insufficiency (following thrombophelebitis) or residual myocardial damage (following repeated myocardial infarction).

Percentage of Cases Developing One or More Thromboembolic Complications

Twenty-five per cent of the control cases in contrast to only 11 per cent of the treated cases developed at least one such complication. This difference is statistically significant. However, of these treated cases, 3.5 per cent developed their first complication before they had received anticoagulant* and 1.5 per cent developed their first thromboembolic complication during the first three days of anticoagulant therapy, before dicumarol is ordinarily fully effective. Thus, 5 per cent developed thromboembolic complications when anticoagulant therapy *could not* have been fully effective and only 6 per cent developed thromboembolic complications while they were actually under the full effect of anticoagulant therapy.

*Included in this group are those who never received anticoagulants because of contraindications.

Number of Thromboembolic Complications Per Hundred Cases

Among each one hundred cases in the control group, thirty-six thromboembolic complications were diagnosed clinically, whereas among each one hundred cases in the treated group, only fourteen thromboembolic complications were so diagnosed. In other words, the patients in the "treated group" experienced slightly more than one-third as many thromboembolic complications as did the control group, a contrast that is again highly significant statistically. This contrast is further emphasized by the following facts. It is noted that five thromboembolic complications per 100 cases developed while the patients were not receiving anticoagulant therapy, and 2.5 thromboembolic complications per 100 cases developed during the first three days of anticoagulant therapy when dicumarol is not considered efficacious. Actually, then, only 6.5 thromboembolic complications per one hundred treated cases occurred in patients who were under the full therapeutic effect of anticoagulant therapy. This figure includes complications in some patients whom we would not now consider to have been under adequate therapy at the time the complication occurred. Autopsies were conducted on 48 per cent of the patients dying among the 800. The autopsy records for these cases are being studied intensively and will yield further light on the effects of anticoagulant therapy on thromboembolic complications.

The highest incidence of thromboembolic complications among the control cases occurred in the age group between fifty and fifty-nine is distinct contrast to the death rate by age groups. The explanation for this contrast may be that, while the younger patients suffer numerous thromboembolic complications and while some of these complications result in serious damage, the younger patients are able to survive them. Thus an individual under sixty may have three or four thromboembolic complications without a fatal episode whereas an older patient may succumb to the initial attack and hence not have an opportunity of developing repeated thromboembolic attacks. This chart clearly

indicates the value of anticoagulant therapy in preventing thromboembolic complications in all age groups. Within the treated group, a distinction is made between those actually receiving anticoagulants and those who were not receiving anticoagulants at the time of their thromboembolic complications. This further emphasizes the effects of anticoagulant therapy.

The rate of thromboembolic complications by week of illness is considered. The advantage in using anticoagulants is clearly demonstrated for each of the first four weeks of the illness. As is the case with deaths, the incidence of thromboembolic complications is highest in the second week, but is marked throughout the first four weeks. This, again, clearly indicates the importance of beginning anticoagulant therapy even as late as the second or third week following a myocardial infarction. Since it is impossible to predict from the condition of the patient during the first week whether he will develop thromboembolic complications during subsequent weeks and whether he will die from them, it is important to give anticoagulant therapy to all patients with coronary occlusion and myocardial infarction unless specific contraindications exist.

Types and Locations of Thromboembolic Complications

Under the classification of secondary myocardial infarctions, there was evidence of extension of the original thrombosis in nine cases per hundred in the controls as against two cases per hundred in those treated. There was infarction of new areas in the myocardium in 6.5 cases per hundred in the controls as against 2.5 among those treated. Pulmonary emboli occurred in 9.4 cases per hundred among the controls as against 5.2 cases among the treated. Moreover half of the so-called treated cases were not actually receiving anticoagulant therapy at the time they suffered their pulmonary embolus. Cerebral emboli occurred in 3.4 per hundred of the control cases as against 1.4 per hundred among the treated cases. Peripheral emboli developed in three per hundred of the control cases as against one per hundred of the treated and venous thromboses occurred in 5 per hundred of the control cases as against less than two per hundred of the treated. Hence, it will be seen that at every site and with every type of complication, those receiving anticoagulant treatment in addition to conventional therapy had a distinctly better chance of escaping thromboembolic complications than those who received the conventional forms of therapy only.

The hazard of hemorrhagic manifestations resulting from anticoagulant therapy has been carefully reviewed. It should be noted that hemorrhagic manifestations unrelated to anticoagulants numbered six per hundred in the control group. This is in comparison to a rate of slightly more than twelve per hundred cases among those patients who were classified as "odd day" or "treated" patients. It should be noted, however, that of these complications in the latter group, two in twelve developed in patients who were not under anticoagulant therapy when their hemorrhages occurred. In an additional three, the hemorrhages were known to be due to causes other than anticoagulants and not to be aggravated by that therapy. The total hemorrhagic manifestations in the treated group which are known to be due to causes other than anticoagulants approaches that found in the control group. An additional seven per hundred cases, however, were believed to be due to, or aggravated by, anticoagulants. The incidence of severe hemorrhages resulting from anticoagulant therapy was extremely low. Of the thirty such hemorrhages clinically observed, fifteen (50 per cent) were mild in severity, fourteen (47 per cent) were moderately severe, and only one (3 per cent) was severe. The autopsy findings on hemorrhagic phenomena are not yet ready for presentation, but those examined to date present no alarming picture of the hemorrhagic risks in anticoagulant therapy under proper controls. Blumgart and his co-workers,[1] working with dogs whose coronary arteries had been ligated, found that dicumarolized animals (in some instances to prothrombin times of 132 seconds) showed no increase of hemorrhages in the myocardium, endocardium or pericardium as compared with nondicumarolized animals.

Sources of Bleeding in Relation to Anticoagulants

There is a definite incidence of hemorrhages among the control group in each of the categories except that for epistaxis. Hemorrhages due to causes other than anticoagulants also occur in three of the categories in the treated group. There will be noted that hemorrhages occurred more frequently in the treated group in all categories except that of hemoptysis. The explanation for the greater incidence of hemoptysis in control patients is that

pulmonary infarction is much more common among these patients than among the treated cases.

The records of patients who received anticoagulant therapy and yet developed thromboembolic complications or died are being subjected to analysis in the Central Laboratory. It appears, on the basis of present experience, that a considerable proportion of the failures occurred because the prothrombin time was not adequately prolonged. While there is at present a question as to what constitutes the minimal effective therapeutic prothrombin time, it is our experience that a safe and effective therapeutic range is between 30 and 50 seconds by Link-Shapiro modification of Quick's one-stage method. This range, as interpreted in our laboratory, would approximate a prothrombin activity of between 20 and 10 per cent. For heparin, the clotting time should be approximately three times normal. Although statistical evidence as to the relative incidence of thromboembolic complications at various prothrombin times (i.e., at various levels of reduced prothrombin activity) is not yet available, a review of those cases in whom thromboembolic complications occurred during the administration of dicumarol reveals that, of the thirty-eight complications* occurring under these conditions, only four occurred in patients whose prothrombin time is known to have been maintained at levels of 30 seconds or more for at least the three days preceding the appearance of the complication. Further analyses regarding this factor will be recorded in forthcoming publications. It is not sufficient to state that a patient has received anticoagulant therapy. Key questions which must be answered are how much, how long, what levels of effectiveness were obtained, and how consistently were these maintained? With this information it should in the future usually be possible to determine whether a failure was the responsibility of the drug or of those administering it.

Summary

This report summarizes the results obtained by a preliminary statistical analysis of the first 800 cases studied by the Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction. In the analysis, the incidence of deaths and of both thromboembolic and hemorrhagic complications has been compared in a "control" series of patients treated by conventional methods alone and in a series of "treated" patients who received anticoagulants (dicumarol, heparin or both) in addition to conventional therapy. The composition of the two groups was found to be essentially the same.

The rates of deaths and the number of thromboembolic complications per hundred cases have been calculated for the control and treated groups as a whole, by week of illness, by age of patient, and by type and location of the specific thromboembolic complication. The percentage of cases developing one or more complications has also been analyzed. The results in every category studied indicate that the use of anticoagulants improves strikingly the outlook of the patient suffering a coronary occlusion with myocardial infarction.

The incidence of hemorrhagic manifestations was also analyzed. It was found that about six minor or moderate hemorrhagic manifestations per hundred cases occur in patients not receiving anticoagulants, but that this incidence is about six per hundred higher in patients receiving anticoagulants. However, only one serious hemorrhage was observed clinically in the entire 800 cases.

Although the minimum prolongation of the prothrombin time necessary to obtain a therapeutic effect from dicumarol in each patient has not been established, it is our experience that a range of from 30 to 50 seconds, as measured by the Link-Shapiro modification of the Quick one-stage technique, produces a safe and an effective therapeutic level. This range of prothrombin times approximates a decrease in prothrombin activity to between 20 and 10 per cent as determined in our laboratory. In using heparin we attempt to prolong the clotting time of whole blood to approximately three times the normal value by the Lee-White technic. In only four cases out of the entire series did thromboembolic complications occur when the prothrombin time had been maintained at a level of 30 seconds or above for at least three days prior to the occurrence of the complication.

Conclusions

1. On the basis of data compiled from 800 cases of coronary occlusion with myocardial infarction, it is concluded that patients treated with anticoagulant therapy in addition to the conventional forms of therapy experience a death rate

(Continued on Page 1351)

*Complications for which the date is not accurately known and those occurring on days for which no prothrombin time is available are excluded from this total, but complications occurring in control cases when under anticoagulant therapy are included.

Medical Diagnosis of Congenital Anomalous Heart

By Saul Rosenzweig, M.D.
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ALTHOUGH the subject of medical diagnosis of congenital anomalous hearts is listed as in the province of pediatrics, it has become of more than passing interest to almost all branches of medicine. To those of us who had some experience in selecting men for the armed forces, congenital cardiac defects were not rare at all, and by incidence were certainly more than the ½ to 2 per cent found in the general cardiac clinic. We were not always able to make full and exact diagnoses with our diagnostic aids, but a bizarre, harsh, persistent murmur and thrill, usually not at an area of the larger cardiac orifices, often associated with an abnormal roentgen silhouette, were sufficient criteria to screen out this type of cardiac. Until recently this sort of diagnostic status was acceptable, and more exact diagnosis was merely academic. I recall recently at an x-ray conference an excellent roentgenologist stating that, until now, he had been very happy to be able to state that the film apparently was that of a congenital cardiac defect. However, today such generalization is not good medicine. The great reason for this change to more exact diagnosis is the tremendous advance in therapy of congenital defects by plastic operations on the great vessels. In this country the lead in this type of surgery has been taken by Gross, Blalock, Potts and others. But to give this impetus to therapy there have been many helpers, without whose significant researches the surgeon might be lost. The diagnostic team now consists of the pediatrician, internist, physiologist, biochemist, roentgenologist, anesthetist and others.

Fortuitously, or because of it, the three types of defect lending themselves best to surgical relief are diagnosed, most exactly, clinically. According to Maude Abbott's original classification, the *acyanotic group* consists of those without any abnormal communication. Of this group the left-sided stenoses, anomalies of cusps, coarctation of the aorta, congenital hypertrophy, situs inversus, anomalies of the aortic arch or pulmonary vessels are examples. And of this group the condition lending itself well to diagnosis, and recently to surgery, is the so-called adult type of coarctation of the aorta.

The *"cyanose tardive" group* of Maude Abbott consists of those with arteriovenous shunt or late reversal of flow; cyanosis is absent except as an incident to terminal venous arterial shunt or congestive heart failure as in any heart condition. Examples of these are defects in the interauricular, interventricular septa, patent foramen ovale, and patent ductus arteriosus. Of this group patent ductus arteriosus lends itself most readily to diagnosis and actually to surgical cure.

The *cyanotic group* consists of those with permanent venous arterial shunt or right sided valvular lesions, usually with septal defects. In these most grave defects there is persistent cyanosis, clubbing, and polycythemia. Examples are absence of septa or cor bi-loculare or tri-loculare, persistent truncus arteriosus, the so-called tetralogy of Fallot, other valvular atresia with associated septal defect, transposition of the aorta. Again, of these, most of which are difficult to diagnose *in vivo*, the most frequent form and best diagnosed is the tetralogy of Fallot; this too lends itself to the partial surgical cure so notably pioneered by Blalock.

Thus it is clear that it is incumbent on us nowadays to give the surgeon an exact clinical diagnosis. What are the methods and criteria for arriving at the correct conclusion as to the exact congenital defects?

The History.—In this branch of medicine, as in all others, the history is paramount. The knowledge of the presence of a heart murmur since birth is almost pathognomonic of a congenital defect. Exception, however, of this rule can occur as occasionally in the hydrodynamics of the circulation changing at birth from a preponderant right to a left may result in a hiatus of some days or longer before the murmur is heard; also in some defects, notably patent ductus, the murmur changes considerably through the first decade of life. It must also be remembered that functional murmurs are most common; it may be ventured that at some time or other under the stress of infection, anemia, et cetera, all children may have such a so-called transient functional systolic murmur.

The Examination.—If cyanosis is present at birth, congenital cardiac defect is usually the first

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suspicion of the physician. This cyanosis increases on effort, and, if doubtful, making the infant cry or the child exercise makes the cyanosis definite. Clubbing is not present at birth but appears relatively rapidly thereafter, even in a few months, and depends upon the degree of the cyanosis or the severity of the defect. This sign usually becomes apparent first in the thumbs. The concomitant presence of cyanosis and clubbing almost always means a serious congenital cardiac defect. However, too many of us use this as the prime criterion of congenital defect. Actually cyanotic cardiacs are a tiny minority of the congenital defects. Therefore, in our examination we must look for *other* signs. As I mentioned before, an *unusual, persistent murmur* in an *unusual location* is significant. If it it is loud, high-pitched, or harsh, often widely transmitted to distant parts of the body, e.g., the top of the head or along the humeri, mostly basal, and associated with a thrill over the area of maximum intensity, cardiac defect is likely. The point of maximum intensity is important and gives a clue to the site of defect. The phase of the murmur is not so significant, as most murmurs of congenital defect are systolic. Notable exceptions to this are patent ductus and the much rarer pulmonary insufficiency. The blood pressure is helpful in two defects: coarctation and patent ductus.

Laboratory Procedures.—The routine blood count is significant in the blue cardiacs; since this cyanosis is largely due to and a compensating mechanism for the abnormally large number of unoxygenated (red) carriers shunted into the left circulation, the resultant polycythemia is characteristic. It may be severe, 8 to 10 million per cu. cm.; nucleated red cells are absent; the plasma volume may be decreased; the white cells are normal in number and type, as are the platelets. The arterial oxygen saturation is often greatly decreased especially in blue cardiacs. The circulation time may be helpful, e.g., a decreased time suggests an arteriovenous shunt.

Roentgenography, Angiocardiography, Kymography.—In the hands of an experienced roentgenologist, routine x-ray and fluoroscopy give most valuable assistance in diagnosis; in fact, no complete picture of the situation is known without his data, even if his information is negative. Some of the things x-ray will tell us are the degree of pulmonary aeration, the size and pulsatile qualities of the pulmonary artery and its tributaries, the shape of the heart—some defects often having classical configurations, e.g., patent ductus. Secondary rib changes in coarctation may be the first evidence picked up of this condition. Kymography is of very limited aid; however, in patent ductus it gives us gratifying objective evidence of the great decrease in cardiac pulsation especially of the pulmonary conus preoperatively and postoperatively. Angiocardiography with contrast substances requires a more special x-ray setup and much experience, is expensive and of some danger to the patient, and thus is not used frequently except in certain centers.

Electrocardiograph.—This is not so valuable a diagnostic aid as the x-ray. Most defects give no diagnostic electrocardiograph pattern, even though the defect is severe. However, the presence of right or left ventricular preponderance in the electrocardiogram does aid in putting the suspected defect in the group of right or left type of defect respectively; thus, left strain is found in coarctation while right strain is found in tetralogy of Fallot. The presence of heart block or a serious arhythmia, while of importance to the physician, is of small help in pinning down the site of the defect. The only condition pathognomonic by electrocardiograms, the mirror heart of situs inversus, is of no clinical significance except as an oddity.

Venous Catheterization of the Heart.—This procedure, known only about six years, gives promise of considerable aid in the diagnosis of congenital defects which may be aided by surgery. By this method, information as to oxygen saturation and other chemical constituents, intracardiac, intraaortic, intrapulmonary pressures, and films of the catheter in the various chambers and great vessels are obtainable. For example, finding a significantly higher oxygen saturation in pulmonary arterial blood than in right ventricular blood makes the presence of an aortic shunt likely; this information is of vital importance in that fairly large group of patent ductus cases with a noncontinuous murmur. Unexpected and abnormal differences in pressure in the various chambers also are of diagnostic inference. The information from catheterization in the blue cardiac is not so exact and more inferential than in the simpler defects; probably catheterization and visualization with diodrast would be a

more advantageous maneuver in this group. The role of the intracardiac electrocardiograph, feasible through the catheter, is likely more of corroborative than diagnostic information. Its exact role is not yet established.

Clinical Aspects of the More Important Defects

Acyanotic Non-shunt Group: Coarctation of the Aorta.—In this not too rare anomaly, the primary defect is constriction or even atresia of a *localized* area of the aortic isthmus. Usually situated at or quite near the insertion of the ductus arteriosus into the aorta, this situation is probably due to faulty involution of the distal left sixth branchial artery which forms the ductus at its junction with the fourth branchial vessel which becomes the descending aorta. This type, termed the adult form in contradistinction to the infantile, is consistent with viability while the latter is not, as in this there is diffuse stenosis of the *entire* isthmus of the aorta. Immediately after birth in this adult type, as the pulmonary circulation is established the aortic obstruction quickly becomes manifest by rise in pressure in the arteries of the upper part of the body. Soon there may be marked dilatation of the proximal aorta while the thoracic and abdominal aorta continue hypoplastic. When the atresia is high grade, large, even visible, anastomoses between vessels from the lower half of the aorta and the proximal aorta occur; this gives rise to the classical sign of this condition, the paradoxical blood pressure—high in the arms and low or absent in the legs.

There are few or no symptoms of this anomaly in children or even young adults, unless there is marked hypertension or other defects, or unless complications ensue, such as failure, apoplexy, thrombosis or bacterial endocarditis. On the other hand, the *signs* are often sufficient to make the diagnosis readily. A rough systolic murmur at the base, at times even better heard posteriorly in the left scapular area, is frequently present unless the constriction is insignificant. A diastolic murmur is not found unless there is the not infrequent associated patency of the ductus. The heart is often enlarged due to the hypertension, and its shape, as in other types of hypertension, is slipper or bootlike. Pulsating superficial arteries, felt or seen in the back, over the head and anterior trunk at times, point unerringly to an easy diagnosis. The paradoxical blood pressure, often 200 mm. systolic or more in the arms and much lower or absent in the legs, occurs in no other disease. Palpation of the femoral artery and taking of blood pressure in legs of every juvenile hypertensive is mandatory; the physical examination otherwise is glaringly incomplete. Maldevelopment of the lower half of the body, with differences in body temperature between upper and lower, may be found. In older children the roentgenologist may embarrass us by first making the diagnosis, for when present, the roentgen signs are as pathognomonic as the paradoxical blood pressure. These signs are (1) an absent or diminutive aortic knob, due of course to the small aorta distal to the site of the ductus; (2) dilatation of varying degree of the proximal or ascending aorta; (3) left ventricular hypertrophy especially when there is well marked hypertension in the arms; (4) most significant, the so-called notching or scalloping of the ribs. This sign is bilateral often symmetrically and consists of erosion of the inferior margins of some or all of the third to the ninth ribs posteriorly. However, this sign is not present until at least the last part of the first decade and is definite by the fifteenth year of life.

Other noncyanotic non-shunt conditions are often oddities such as situs inversus, simple right aortic arch, and are thus of no diagnostic or clinical significance. Grave conditions such as idiopathic hypertrophy including von Gierke's disease, ectopia cordis, are usually diagnostically obvious but often non-viable. For purposes of this discussion, such rarities as dysphagia lusoria, subaortic stenosis, cusp anomalies, congenital mitral stenosis, pulmonary insufficiency are perhaps not germane.

Cyanosis Tardive Group—Arteriovenous Shunt: Patent Ductus Arteriosus.—This fairly common condition is not truly a defect in development but merely the persistent patency of a major intrauterine vessel, the ductus arteriosus, which connects the pulmonary artery to the aorta but which normally closes physiologicaly a few minutes after birth and by fibrosis rapidly thereafter. Failure to close may be due to inadequate oxygenation of blood because of insufficient aeration and expansion of the lungs immediately after birth. Secondary to perisistent patency there occurs dilatation of the pulmonary artery and its major tributaries, and if the shunt of aortic blood to the pulmonary artery is high grade, there occurs eventually definite enlargement of *both* ventricles.

As a rule there are no symptoms unless failure with cor pulmonale ensues or complications de-

velop, such as bacterial endocarditis. Of all congenital defects in this group, the signs of this condition render diagnosis by physical means not difficult. The classical murmur, when present, as it is in about 80 per cent of cases, is pathognomonic. It is best described as harsh, machinery type, continuous through both phases of the cardiac cycle. However, early in life it is usually systolic in type, but by the seventh year it is biphasic, if it is to become so. It is best heard in the second or third left interspace and left subclavicular area but may be widespread and is most often associated with a thrill of the same phases. The reason for a continuous murmur is that the diastolic arterial pressure is higher than that of the pulmonary system and thus there is a continuous reason for the production of a murmur in both phases of the cardiac cycle. The second pulmonic heart sound is usually heard as accentuated midway in the murmur. In those cases where the murmur is monophasic and the diagnosis becomes essential for possible surgical relief, as mentioned before, intracardiac catheterization may give the diagnosis with fair exactitude; we believe this is the major exception to the dictum: "No biphasic murmur, no operation." The blood pressure is suggestive of the condition when the shunt is considerable and is similar to the Corrigan pulse of aortic insufficiency, i.e., high pulse pressure, the systolic however not usually elevated, capillary pulse and pistol shot in the femoral. The x-ray is of considerable aid, although when the ductus is small the heart size and shape are normal; when the ductus is large the film and fluoroscopy are characteristic. There is marked prominence at and above the site of the pulmonary artery, at times termed the "ductus cap." Fluoroscopy reveals the so-called "hilar dance" which is due to the pulsating large pulmonary vessels at the lung hila. The electrocardiogram often shows left ventricular preponderance. Conditions which may need differentiating from patent ductus are interauricular septal defect and aortic septal defect; the type and location of the murmur, the peripheral signs, and the x-ray will often be sufficient; intracardiac catheterization will aid in these doubtful cases. Interventricular septal defect usually is not confused with patent ductus as the typical harsh systolic murmur and thrill of Roger at the third and fourth left interspace occurs practically in no other condition.

Cyanotic Group: Venous Arterial Shunt—Tetralogy of Fallot.—In approaching the diagnosis of this condition, a simple rule is of great aid, i.e., "all congenitally blue cardiacs are tetralogies until proven otherwise," as from three-fourths to nine-tenths of all such cases are pathologically of this type. The primary defect of the tetrad is failure of development of the conus arteriosus; this gives rise to (1) pulmonary or infundibular stenosis or atresia, (2) patent interventricular septum, high in the membranous portion, (3) overriding of the aorta at the site of the patent septum, i.e., detroposition of the aorta, and (4) compensatory right ventricular hypertrophy.

There usually are symptoms in this condition. Dyspnea is often present, the child often assuming a squatting position after light exercise in attempting to catch his breath. Cough is frequent, weakness, maldevelopment and complications such as thromboses, pulmonary hemorrhage, convulsions are not infrequent. The physical examination shows the characteristic clubbing and cyanosis already mentioned. In the pulmonic area, systolic murmur and thrill are usually present, the intensity being in proportion to the cyanosis rather than the degree of pulmonic stenosis, for if the stenosis is high grade no murmur may be heard. As compensation for the pulmonary deoxygenation and because of the overworked respiratory system, there may develop kyphosis and spinal deformity. The x-ray findings are usually characteristic; the apex is high, at times appearing as a double tip, and is of course due to the right ventricular hypertrophy, but there may be no over-all enlargement of the silhouette. The area of the conus is concave or scaphoid in all cases. In the anterior oblique view, Helen Taussig pointed out that the pulmonary window is unusually clear, the pulmonary markings at the hila are minimal, and the lungs unusually clear. Fluoroscopy shows the dextroposed aorta and the absence of hilar pulsations. About one-fourth of the cases show a right aortic arch on fluoroscopy with barium. The typical polycythemia has already been mentioned, as well as the suggestive electrocardiogram with right ventricular preponderance, extreme voltage and huge P waves.

The only blue cardiac necessary to be differentiated is that wastebasket diagnosis, the Eisenmenger complex, in which insufficiency of the pulmonary vessel rather than stenosis is supposed to oc-

cur. In this a diastolic murmur may be heard. The x-ray shows a globular heart, no concave conus, no clear window, but pulsating hila. It is obvious that in this type of lesion a shunt into the pulmonary system already physiologically exists, and another made artificially will not be indicated. The various types of transposition of the great vessels, common truncus and cor triloculare are not readily diagnosed *in vivo* and are probably not suitable for discussion in this brief paper, although perhaps ameliorated by surgery.

Conclusion

In conclusion, I might state that this résumé of the problems of diagnosis is of course very incomplete. I have been forced to omit discussion of all defects but those lending themselves to modern surgical relief and/or cure. However, it is encumbent for us to make these diagnoses exactly and early in life to give our patients their best chance. With the rapidly advancing strides in chest surgery and the newer safer methods used by our anesthesiologists, the prognosis for these cardiacs is immeasurably improved.

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REPORT OF COMMITTEE, AMERICAN HEART ASSOCIATION

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and incidence of thromboembolic complications during the first six weeks period following an attack markedly lower than those experienced by patients treated solely by conventional methods.

2. Anticoagulant therapy should be used in all cases of coronary thrombosis with myocardial infarction unless a definite contraindication exists.

3. In the absence of hemorrhagic conditions the hazards from hemorrhage are not sufficient to contraindicate the use of anticoagulants in coronary occlusion providing there are facilities for adequate laboratory and clinical control.

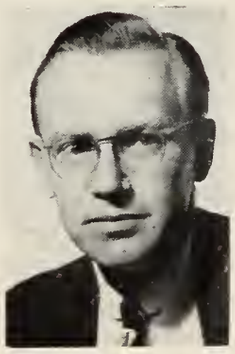
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Large Pancreatic Cyst

Case Report, General Discussion and Review of the Literature

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AN INTRAABDOMINAL tumor, large enough to be seen or palpated with ease by the examining physician, has always been an interesting diagnostic problem, particularly when there is little or no complaint leading up to its discovery. With this thought in mind, a case history revealing a rapidly growing pancreatic cyst which attained great size in a young woman is added to the literature of reported pancreatic abnormalities. Although a presumptive diagnosis of cyst of the pancreas was made prior to operation, the differential diagnosis included hepatic, mesenteric, omental or splenic cyst; hydrops of the gall bladder; retroperitoneal neoplasm; hydronephrosis; and more remotely, aneurysm and ovarian cyst.

C.Y.K., white female nurse (student), age twenty, was admitted to Community Hospital March 12, 1946, complaining of a fullness of the upper abdomen, a visible swelling which was growing in size. This was discovered on examination for entrance to training March 8, 1946. She first noted this fullness in October, 1945, but had only recently noticed some pain in her back and abdomen on exertion.

Personal history revealed a good appetite, no complaints of indigestion, constipation or diarrhea. Her temperature was 99 degrees F., pulse 80 per minute, weight 163 pounds. Blood pressure was 112/80. In the left upper abdomen there was a soft, cystic mass visible with the patient supine, exaggerated in size on standing. This filled the left upper quadrant, was 18 to 20 centimeters in diameter, could be moved very little. Fixation seemed deep in the abdomen, and a firmer portion of the mass was felt on deep palpation, eliciting tenderness.

Catheterized urine showed no albumin, sugar or bile, and contained 1 to 2 WBC/HPF. Hemoglobin was 88 per cent, white blood count 9,500, and red blood count 4,100,000. Serum amylase showed 143 milligrams of amylolytic activity (normal 30 to 100 milligrams). Gastrointestinal x-rays (Fig. 1) revealed marked displacement of the stomach downward and to the right. The cecum was dilated, low and the splenic flexure was displaced downward. The left diaphragm was elevated. Because of incomplete visualization of the left kidney



Fig. 1.



Fig. 2.



Fig. 3.

by intravenous pyelograms, cystoscopy and retrograde pyelograms were done and were negative.

Laparotomy was done March 26, and a tense thin-walled cyst appeared as the peritoneum was opened. This seemed to arise from the liver, the thickest portion of its wall having a reddish cast like hepatic tissue and was so thin anteriorly that one area seemed ready to rupture. Trochar aspiration produced more than 5 liters of straw-colored fluid, with fatty globules (additional fluid escaped into large abdominal packs plus a small amount left in the cyst). Exploration showed the cyst arising above the head of the pancreas in a long stalk which crossed the lesser curvature of the stomach through the gastrohepatic ligament. The pancreas was normal in size and consistency. The cyst adhered to the upper edge of the spleen, was freed, marsupialized and packed. Postoperative diagnosis was pancreatic cyst. A piece of the cyst removed for microscopic study showed a fibrous wall with dense lymphocytic infiltration, granulation tissue with areas of cuboidal or ovoid cells forming a lining and many cholesterin crystals. Tests for trypsin and bile were negative. Pathological diagnosis was pancreatic cyst. The packs were removed under anesthesia on the ninth postoperative day, releasing over a pint of dark brown fluid, and were replaced by two soft rubber tubes. A drop in blood total proteins to 5.4 grams was corrected by oral protein therapy.

On the twenty-sixth day after operation the cystic cavity held 5 ounces of normal saline, and five days later 50 per cent Skiodan was injected (held 200 cubic centimeters) for x-ray study (Figs. 2 and 3). The opaque shadow measured 4 inches and extended backward into the retroperitoneal space under the left lobe of the liver. Drainage from the sinus was only moderate, and the wound healed rapidly around the tubes. Skiodan injection was repeated eight weeks after operation, the cavity holding three ounces (Fig. 4); again twelve weeks postoperatively (Fig. 5) at which time only 1 ounce was retained, and sixteen weeks after operation (Fig 6) when no Skiodan was retained, and report was given that "the sinus has entirely closed." Two cubic centimeters of sclerosing solution (Etalate) were injected into the sinus June 23 without any untoward reaction. This was repeated July 1 and again on July 16. On August 27 the sinus was only one-half inch deep and healed rapidly in a few weeks.

Check-up examination was done November 29 and showed excellent healing, a strong scar and no subjective complaints. Final examination May 3, 1947, more than a year after operation, found the patient in excellent physical condition, complaining only of a mild pulling sensation in the upper abdomen which followed exercise. There was slight dimpling at the site of drainage in the scar. Physical examination and laboratory studies showed no abnormality. She was leading a normally active life. An attempt to obtain a report by letter November, 1947, was unsuccessful; the patient could not be traced.

Cyst probably was the first disease of the pancreas to be treated surgically[27] for Morgagni[38] described multiple cysts on the pancreas in a cadaver in 1761, and Claessen[12] reviewed a series of cases from the literature in 1842.

Frequency

Reports from surgical clinics and teaching hospitals attest to the infrequent occurrence of all types of pancreatic cysts. White[56] found only three cases in 6,708 autopsies done at Guy's Hospital, London. Only nine cases were observed at the Lahey Clinic[1] from its origin in 1926 to October 1, 1945. Seven cases of cyst were found among 158 surgical lesions of the pancreas at Johns Hopkins Hospital[47] from 1889 to 1932. Judd[27] reported forty-one cases in 1921, the largest original series up to that time, and later[28] an additional forty-seven cases or a total of eighty-eight pancreatic cysts from 723,397 patient admissions to the Mayo



Fig. 4.



Fig. 5.



Fig. 6.

Clinic. In 1941[54] this same group reported fifty-one more cases to record the largest series published by any one clinic. Six cysts[26] were reported from twenty-one pancreatic cases at Hurtl's Clinic 1923 to 1936, and a questionnaire directed to over 100 European clinics[49] culled 2,137 cases of acute pancreatic necrosis from their records with only 128 cases of cyst. Only five pancreatic cysts were found in the surgical records of Massachusetts General Hospital[57] from 1920 to 1937.

Incidence

This is a disease of middle life, occuring most often in individuals between the ages of twenty and forty years. There are a few reports of true pancreatic cysts in infants, among them[18] a congenital cyst in a female, five months old, which was successfully removed from the tail of the pancreas. Although some of the recent reports find the two sexes affected with equal frequency, the literature favors a moderate predominance in females.

Classification

Thigpen's[53] etiologic classification of pancreatic cysts, derived from an extensive review of the literature has been published by Walters and Cleveland[54] as follows:

1. Pseudocyst, a cyst without an epithelial lining, the result of trauma to or inflammation of the pancreas.
2. Retention Cyst, which results from obstruction to the outflow of secretion by calculi or by pancreatitis.
3. Neoplastic Cyst including cystadenoma, cystadenocarcinoma, sarcoma, teratoma.
4. Cyst Resulting from Defective Development.
5. Parasitic Cyst, such as the hydatid variety.

The rare dermoid cyst[27] might be added to this as a separate classification. Only three such cases[16] have been reported.

Retention cysts are the most common type and are rarely large, occurring in the head or body of the pancreas. Parasitic cysts are infrequent.

Cysts from defective development are of varied nature, some similar to the congenital cysts of the kidney and liver. They may arise from misplaced remnants of Brunner's glands[46]. Hemangiomas of the pancreas are included in this group.

Neoplastic cysts are rare, comprising only four and one-half per cent or two of 108 cases from the Mayo Clinic. There were two in the nine cases of cyst reported from the Lahey Clinic. Individual case reports[4,5,6,8,9,29,41,57] are infrequent and Jemerin[24] very recently published the twenty-ninth case of cystadenoma recorded in the literature. A malignant polycystic tumor similar to those in Lindau's disease[36] and a 7-liter cyst with cells of Langerhans "like fibroplastic sarcoma"[38] are among the less common types.

Pinkham[44] has published an excellent discussion of the etiology of pancreatic pseudocysts and collections, listing trauma, acute and chronic pancreatitis and hemorrhagic necrosis of this organ as leading causes. Degenerative changes within the gland lead to cyst formation within the pancreas, while the corrosive action of pancreatic ferments released into the lesser peritoneal sac produce encapsulated collections about the gland. In either type the surgeon will usually find the cyst in one

of three locations, between the stomach and the transverse colon under the gastrocolic omentum; between the stomach and the liver, under the gastrohepatic omentum; or between the layers of the transverse mesocolon. Dense connective tissue forms the wall of a pseudocyst, and it may be lined by endothelium. The true cyst is lined by epithelium, which if destroyed by pancreatic ferments makes its differentiation from the pseudocyst impossible.

Varied accounts of minor to severe crushing injuries of the abdomen producing few initial symptoms and moderate discomfort, up to surgical emergencies presenting severe acute abdominal symptoms are found in the literature[2,15,17,21,22,25,33,34,37,42,49,50] and lately there have been some reports of acute trauma to the pancreas from war injuries.[32] Selecting figures given by seven different writers, the number of cysts resulting from trauma varies from 12 per cent (von Schmieden) to 33 per cent (Heiberg), averaging 20 per cent.

Held[23] distinguishes pseudocyst as forming shortly after trauma and true cyst as occurring long after the initial injury. Hemorrhage of and trauma to the pancreas form the basis for the development of cyst. Some cysts following known trauma represent hematomas of the lesser omental bursa, while others have clear, cloudy or deeply colored fluid according to the action of the ferments released.

The role of acute and chronic pancreatitis[1,10,14,28,44,52] as an etiologic factor in the production of true and false cysts has received increasing emphasis lately. The mechanism involved is problematic, although most observers feel that fibrosis of the gland constricts the pancreatic ducts producing obstruction and dilatation beyond the area blocked. Chronic cholecystitis and other types of biliary tract disease,[6,10,14,28,37,44] common bile duct obstruction, and portal vein obstruction are commonly associated with pancreatic cysts and must be included in the list of important causative factors. Although hemorrhagic necrosis of the pancreas may damage the gland more extensively than trauma, pseudocyst formation follows in much the same sequence as it does from trauma, and the cysts are alike.[28,37,44,49]

The pseudocyst is usually unilocular, varying from five to 35 centimeters in diameter. Large cysts are unusual and may require heroic surgery for their removal. They may contain four liters of fluid[1,21,35,44] 5 liters,[40,45] 6 liters,[35] 7 liters[38] and rarely 20 liters.[23,35] Since it is rarely possible to distinguish between hematogenic collections, pseudocysts and pancreatic suppurations at operation or at autopsy, it has been suggested[35,44] that the terms "false" or "pseudocysts" be discarded. Instead, the term pancreatic cyst or collection resulting from trauma, duct obstruction, acute and chronic pancreatitis, or pancreatic necrosis should be substituted.

Symptoms

Pain is the most constant symptom of pancreatic cyst, found in 85 per cent of patients and is described as dull and steady, or severe and colicky, occurring in the epigastrium, left upper quadrant, or radiating into the back. Nausea, vomiting, weakness, weight loss and even jaundice are later symptoms. Mild persistent flatulence, sense of pressure and anorexia are often present.

Signs

A palpable mass in the upper abdomen, usually the left upper quadrant, is the most constant sign. Several cases of pancreatic cyst accompanying pregnancy which sometimes complicated the diagnosis[35,43,45] are recorded. One cyst containing five liters of fluid was found following delivery.

X-ray plays an important rôle in the diagnosis, the stomach and bowel being moderately or considerably displaced, and the duodenal loop may show considerable widening. A flat plate of the abdomen may reveal the outline of a cyst. Cholecystogram[7] may show a distended gall bladder whose opaque shadow persists much longer than usual (several days instead of thirty to sixty minutes) due to obstruction to the escape of bile, and in late stages the gall-bladder shadow is no longer seen. Gastric pneumograms have been done in some clinics with success, using the posterior wall of the distended stomach to outline the pancreas.

Laboratory studies may not be very helpful, but often a blood serum amylase well above normal can be demonstrated to substantiate the diagnosis of pancreatic cyst. Trypsin, when present in the fluid obtained from a cyst identifies its pancreatic origin. Diabetes has been reported in five to eight per cent of these cases[44] and Bowers[6] found diabetes in three of five cases presented.

Complications

Rupture of a distended pancreatic cyst into the abdomen or into some hollow viscus[29,34] is a rare complication which should be considered in the

differential diagnosis of acute abdominal conditions. Accompanied by considerable shock and evidence of peritonitis, the mortality from this accident in the largest series of cases reported was 66 per cent. Sudden hemorrhage into a cyst may simulate an abdominal emergency, is usually diagnosed as peritonitis preoperatively[25,41,44] and may cause collapse of the patient. At operation the abdomen may be filled with blood. Obstruction of adjacent organs by direct pressure of a large cyst or an adherent cyst is a late complication, resulting in symptoms of intestinal obstruction, vomiting, or diarrhea.

Treatment

Total excision is now the treatment of choice [1,3,10,15,28] in all but the very large pancreatic cysts, or adherent growths which defy surgical removal, and is the particular treatment of cystadenoma and other malignant types.[4,5,8,9,13,15,24,36] The cyst is often incised at its base and enucleated, and at times partial pancreatectomy[48] may be required for complete removal. Proponents of total excision score the long draining sinus (eight months up to fifteen years) which may follow marsupialization and drainage,[20,28,30,33] a fistula which may lead to death from retroperitoneal sepsis and thrombophlebitis of the inferior vena cava.

Anastomosis of a pancreatic cyst to an adjacent hollow viscus, the duodenum, jejunum, gall bladder or stomach has gained favor recently[1,26,31,32,40,51] and is an excellent cure for the chronic fistulous tract which sometimes follows marsupialization.[3,11,13] This may be done for the adherent cyst and for the cyst with large vessels in its wall.[6]

Marsupialization and drainage has been a satisfactory and final type of treatment for benign cysts in the experience of most surgeons.[13,37,55] The time limit for automatic closure of a postoperative fistula is about nine months, after which measures for its exclusion are indicated. Silver nitrate irrigations[17] have accelerated the obliteration of a sinus, while some report good success with the use of sclerosing solutions such as sodium morrhate.[19] Tincture of iodine has been used to destroy the lining of a cyst. Direct introduction of radium into the sinus and x-ray therapy[20] over it, or a combination of both have been used with success.

Summary

Although published clinical records of pancreatic cyst are increasing in the medical literature, the condition remains a rare occurrence in the experience of most surgeons. From individual reports as well as those from large hospitals and clinics it appears that any one surgeon may encounter one or two pancreatic cysts in his lifetime. Many will never have this experience.

This case was considered worth discussion because of the considerable size of the cyst; its rapid growth with few accompanying symptoms (only mild discomfort); the serial x-ray studies taken before and after surgery demonstrating rapid decrease in its size; the absence of any obvious etiologic factor in its production; the complete obliteration of its sinus with the aid of a sclerosing solution; and the successful clinical result without residual effects. In this review, the current literature on pancreatic cyst has been brought up to date.

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Cervical Sympathetic and Stellate Ganglion Block in Apoplexy

Preliminary Note on Indications and Technique

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THE RATIONALE for interrupting sympathetic impulses to the region of the brain involved in a vascular accident has only recently become partially accepted.

In the past, it was widely held that the cerebral circulation was very little altered by emotional stress, and that the vasomotor nerves in the brain were weak in comparison to vasomotor impulses elsewhere in the body. The role of the carotid sinus and aortic depressor mechanisms in maintaining a constant tonus of cerebral vessels was emphasized by Soma Weiss[8] in 1938.

However, Villaret and Cachera[6] in Paris demonstrated in animal experiments, utilizing a window in the skull, that after occlusion of a cerebral (pial) vessel, reflex vasospasm, and diapedesis of red cells following venostasis in the area about the occlusion occurred. These phenomenon, which could be abolished by blocking cervical sympathetic nerves, were similar to those observed in vascular occlusion elsewhere in the body, and demonstrate in retrospect that the principles applying to vascular disease in general, likewise, hold in vascular disease involving the central nervous system.

Stellate ganglion block for hemiplegia was first performed by Leriche and Fontaine.[4] In two cases of postoperative hemiplegia, they infiltrated the stellate ganglion of the affected side with a marked regression of symptoms. They believed that the block released vasoconstriction about the lesion (ischemic or hemorrhagic) with resultant diminution of edema. Mackey and Scott[5] obtained good results in nine patients in a series of nineteen cases of acute cerebrovascular accident treated with cervical sympathetic block.

Their criterion for success was rapid improvement of symptoms because it is well known that in some cases of apoplexy, spontaneous improvement may occur within the first few hours. They found that cases of cerebral embolism in young patients responded most dramatically of any type of apoplexy. Good results were obtained in cerebral thrombosis and poor results were obtained in cases of cerebral hemorrhage. Volpitto and Risteen[7] in this country confirmed the poor results in cases of cerebral hemorrhage and reported encouraging results in cerebral thrombosis when stellate ganglion blocks were employed.

In March, 1948, de Takats and Gilbert[2] created great interest in this procedure by reporting dramatic improvement in nineteen of twenty-five patients with early apoplexy treated with cervical sympathetic block. Their report heralds a new era of active treatment for a condition in which previously, by and large, treatment has been considered pretty hopeless by the medical profession. These investigators again stressed the importance of differentiating between cerebral embolism, thrombosis (or softening) and hemorrhage. Apoplexy due to hemorrhage was not treated with cervical sympathetic block. This type of apoplexy is highly fatal, and the mortality resulting from it is 77 per cent at St. Luke's Hospital, Chicago. In properly selected cases (acute apoplexy due to embolism or thrombosis), regain of consciousness and of speech, motor improvement and conversion of flaccid into spastic paralysis were observed. In order to credit the improvement to the sympathetic block, regression of symptoms must occur within ten to twenty minutes following the block.

Indications for Cervical Sympathetic Block

As the purpose of this report is to bring this procedure to the attention of the physicians in this state and to further encourage a more active treatment of apoplexy, the indications and technique in use at our clinic since April 1, 1948, will be outlined. As our series of cases is still too small to be significant, an analysis of results must await further experience.

Patients with acute apoplexy or with residual symptoms resulting from old cerebral vascular accident are admitted on the medical service either to the hospital as bed-patients, or to the clinic as

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out-patients, depending upon the seriousness of their disease.

In the case of patients with acute apoplexy, lumbar puncture is performed immediately after admission. If the spinal fluid is bloody and under increased pressure, the diagnosis is assumed to be cerebral hemorrhage. Sudden onset of symptoms, markedly elevated blood pressure, increased white cell count, stiff neck and deepening coma are further signs of hemorrhage. In this type of patient, cervical sympathetic or stellate ganglion block has not yet been employed.

If the spinal fluid is clear with elevated pressure, if the coma is not deep and not progressive and the hypertension moderate, the presumptive diagnosis is cerebral thrombosis and the patient is referred to the surgical department for cervical sympathetic block. It should be stated that cerebral embolism must be ruled out before making a diagnosis of cerebral thrombosis, although the immediate treatment insofar as sympathetic block is concerned, is the same. In general, embolism is diagnosed when the patient has an obvious cardiac lesion, either rheumatic (usually with fibrillation) or due to a myocardial infarct. These patients have clear spinal fluid without an elevated pressure and are often of younger age.

In patients with chronic sequelae of old vascular accidents, the differential diagnosis from the standpoint of using sympathetic block is not so important because one is attempting to treat the late circulatory disturbances produced by cerebral infarction which may continue to play a role in the pathogenesis of sequelae such as hemiplegia, dysarthria, and causalgia. We have recently seen a patient with hypertension who had a small vascular accident (presumably thrombosis) which interfered with the blood supply of the left eighth nerve. This accident was heralded by the sudden onset of left complete eighth nerve deafness and Ménière's syndrome (tinnitus, headache, nausea, vomiting, and dizziness) indicating that both acoustic and vestibular branches of the eighth nerve were involved.

As would be expected, the results of sympathetic block in the cases of long duration are not at all as dramatic as in acute cases. The present writer has performed some twelve blocks, either of the cervical sympathetic chain or stellate ganglion, on ten cases of long duration in the course of perfecting the technique of the procedures. In about half of these, no benefit of any degree was observed. It is of interest that in the first patient in which cervical sympathetic block was performed three months ago a year after an attack of cerebral thrombosis, incapacitating dysarthria was completely relieved for twenty-four hours, and causalgic occipital headaches have been relieved up to the present writing. This patient had almost no residual hemiplegia so that no evaluation of the effect of the block on this sequela was possible.

In an acute case of cerebral thrombosis, coma and hemiplegia were dramatically relieved within five minutes after production of a Horner's syndrome. The symptoms returned, and a second block the following day was much less beneficial. The patient, a fifty-year-old man from Dexter, Michigan, was scheduled for a bilateral supradiaphragmatic sympathectomy, and splanchnicectomy for malignant hypertension, but died the night before the operation.

Technique

The technique of cervical sympathetic block can be mastered by any physician, whether surgeon, internist or general practitioner, if certain precautions, to be discussed, are kept in mind. Stellate ganglion block is a dangerous procedure except in the hands of a surgeon versed in the procedure and employing it only in a well-equipped hospital. This danger is due to the fact that the stellate ganglion is located behind the uppermost portion of the dome of the pleura and the needle can puncture the pleura producing pneumothorax and even massive collapse of the lung. For the occasional operator, cervical sympathetic block is safer, easier, and just as effective therapeutically in the treatment of apoplexy.

Cervical sympathetic block is done either in the operating room, if the patient can be conveniently and safely moved, or with the patient in his bed. As with all procaine injections, 2 mg. of sodium phenobarbital or other barbiturate are given preoperatively to lessen the risk of a procaine reaction.

The patient lies on his back with his neck hyperextended. A pillow is placed under the shoulder of the side of injection (the side of the central lesion), and the head is turned away from the site of the injection. If the posterior border of the sternocleidomastoid muscle is not prominent, the patient is asked to raise his head against the pressure of the operator's hand. This border is

located prior to palpation of the transverse processes of the cervical vertebrae. The site of injection, posterior to the sternomastoid border above the clavicle and over the transverse process of the sixth cervical vertebra, is painted with merthiolate, and the rest of the neck is draped. A dermal wheal is placed with a 1 per cent solution of procaine hydrochloride (without epinephrine) over the tip of the sixth transverse process. A lumbar puncture needle with stylet is inserted through the wheal until it makes contact with the tip of the transverse process. The needle slides anteriorly and medially until the point lodges in the groove at the juncture of the transverse process and the body of the vertebra. When the needle point is in contact with the vertebral body, aspiration is done for blood, spinal fluid, and air. If none of these is observed, 15 to 20 c.c. of a 1 per cent solution of procaine hydrochloride are injected slowly with occasional aspirations during the procedure. While we have not yet used proctocaine or other longer-acting preparations, we are contemplating their substitution for procaine in the near future.

The stellate ganglion is blocked anteriorly by placing the needle lower and sliding its point down over the anterior surface of the transverse process of the seventh cervical vertebra. The needle is inserted at an angle so that its point will be medial to the dome of the pleura. The techniques of Leriche and Fontaine[3] and of de Bakey and Ochsner[1] should be studied prior to attempting stellate ganglion block which is, as stated, unsafe in unskilled hands.

All successful blocks are followed within five to ten minutes by a Horner's syndrome of the affected side; this is characterized by myosis, drooping upper eyelid, dryness and warmth of the affected side of the face and dilatation of the conjunctival vessels.

A failure to obtain a Horner's syndrome warrants a repeat of the block as it indicates that the first block was unsuccessful. In early cases of apoplexy having quadriplegia, bilateral blocks in two stages are recommended. It is altogether possible that bilateral sympathetic blocks will prove with further experience to be superior in all cases of apoplexy. At present, our experience is limited mostly to unilateral block on the side of the lesion. In general, if a successful block followed by a Horner's syndrome has not resulted in clinical improvement, we have not repeated it. The successful block is repeated only if encouraging relief of symptoms has been obtained.

Summary

It can readily be seen that the clinical evidence favoring the value of cervical sympathetic and stellate ganglion block in apoplexy is much stronger than experimental evidence, yet the studies of Villaret and Cachera alluded to offer convincing proof that cervical sympathetic block relieves vasospasm, diapedesis and transudation in the zone of cerebral tissue surrounding a vascular occlusion.

All students of this procedure are agreed that cases of cerebral hemorrhage should be eliminated before a block is carried out for apoplexy. However, the final judgment in this connection has not yet been made.

The technique of cervical sympathetic block can be learned by the physician in general practice, in a small community, or elsewhere, and can be done safely if certain precautions discussed are remembered. It appears that definite therapeutic help may be rendered to properly selected patients. The technique for stellate ganglion block by the anterior approach is dangerous and is recommended only for those properly versed in this procedure, employing it in well-equipped hospitals. A discussion of stellate ganglion block by the posterior approach for the treatment of angina pectoris or of causalgia of the upper extremities is not within the scope of this communication. While general measures in the treatment of acute apoplexy, such as oxygen administration, catheterization of the urinary bladder and so on, have not been discussed, these, of course, cannot be neglected.

The management of apoplexy at this hospital has been outlined with regard to the use of cervical sympathetic and stellate ganglion block. Some preliminary impressions regarding the efficacy of these procedures have been mentioned.

Author's Note: I am indebted to Dr. Geza de Takats of Chicago for helpful criticism during the preparation of this report. He has pointed out that chronic invalids should not be given false hope that such procedures will alleviate their invalidism except in some cases of thalamic pain, causalgia, and so on.

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Incidental Appendectomies

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IN THE Department of Obstetrics and Gynecology at the University of Michigan Hospital, incidental appendectomy has long been almost a routine procedure at the time of laparotomy. Unless some contraindication existed, this has been our regular practice. Because the pathology report returned on these appendices usually revealed the presence of chronic, and sometimes active, disease, the following questions were raised:

1. Is the appendix a readily, a repeatedly, and a chronically diseased structure?

2. Are we jeopardizing or benefiting the patient by the removal of the appendix at the time of major pelvic surgery?

With this in mind, 160 consecutive laparotomies for abdominal hysterectomy, a major pelvic procedure, were analyzed statistically.

Since appendicitis is commonly a disease of adolescence, we were interested in the age grouping of our patients. The extremes were twenty and seventy-one years. The average age was forty-four years, which is beyond the age of highest incidence for appendicitis.

Our 160 patients were divided into three groups, as shown in Table I.

TABLE I. APPENDECTOMIES IN RELATION TO HYSTERECTOMIES

Group	*No.*	*Percentage*
Appendectomy with hysterectomy	70	44%
Appendix already removed	48	30%
No appendectomy with hysterectomy	42	26%
Total	160	100%

In seventy (44 per cent) we performed an incidental appendectomy. Forty-eight (30 per cent) of our patients had already had an appendectomy in the past because of acute appendicitis or incidental to other surgery. Forty-two (26 per cent) did not have an appendectomy with our operation presumably because some contraindication existed.

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Since most of the appendices removed were reported as being the seat of chronic and sometimes active infection, we were of course interested in knowing whether clinical signs and symptoms of appendicitis had been present preoperatively in the seventy appendectomized cases in our series.

TABLE II. PREOPERATIVE SIGNS AND SYMPTOMS

Pain or tenderness in right lower quadrant	7
Nausea and vomiting	1
Temperature elevation over 99.6° F.	0
Leukocytosis over 10,000	0

In only seven (10 per cent) of these patients was there a history or clinical findings which might have been interpreted as indicating the presence of a diseased appendix (Table II). These signs and symptoms were usually attributed to other causes. In only two cases was one of the tentative preoperative diagnoses that of appendicitis. Whether these patients had had attacks of appendicitis in the past could not be determined by reading the patients' records.

Since most of the removed appendices were reported as pathological, we were interested in learning what the surgeon found at the time of operation. In the record most of the seventy appendices removed were described as benign in appearance, or else no description was given. In only nineteen (27 per cent) was some abnormality as to position, inflammation, fibrosis, vascular change, dilatation of the lumen, concretions, or adhesions noted. Fifty-one (73 per cent) were thought by the operator to be normal. In spite of the fact that in nineteen some abnormality was noted, in only one case was the clinical diagnosis of chronic appendicitis made.

Considering these facts, namely, the lack of preoperative signs or symptoms of appendicitis and, secondly, the absence of clinical or gross manifestations of inflammation in the appendix when viewed directly, the question arose as to what the pathologist saw through the microscope that was so indicative of recurrent and sometimes active infection in the appendices incidentally removed.

Table III divides into unit statements what the pathologist saw in the seventy appendices removed incidentally to pelvic surgery.

The crux of the problem lies in whether the changes listed represent evidence of repeated infections or changes coincident with age.

Fibrosis of the submucosa and/or the subserosa, present in forty-one of the appendices removed, may possibly be considered as a change of age. On

the other hand, structurally the appendix is essentially the same as the gut and we do not see this degree of fibrosis in the gut with age.

TABLE III. MICROSCOPIC REPORT OF SEVENTY APPENDICES

Fibrosis of submucosa and/or subserosa	41
Recurrent appendicitis and periappendicitis still active	35
Recurrent appendicitis and periappendicitis	30
Dilatation of appendiceal lumen	15
Fecal concretion or other foreign bodies in lumen	14
Lymphoid hyperplasia	10
Obliteration of distal ⅓ of lumen	10
Obliteration of distal ⅔ of lumen	4
Complete obliteration of lumen	8
Periappendiceal adhesions	8
Purulent exudate in the lumen	4

In sixty-five of the seventy appendices removed, the pathologist reported recurrent appendicitis and periappendicitis; in thirty-five of these some degree of active infection was noted. This was not a matter of professional courtesy since these were incidental appendectomies and the pathologist reported merely what he saw through the microscope.

If our theories as to the etiology of appendicitis are correct, then dilatation of the appendiceal lumen and fecal concretions or other foreign bodies in the lumen, present in fifteen and fourteen cases respectfully in our seventy appendectomized patients, represent factors that are, or can lead to, appendicitis.

Lymphoid hyperplasia is considered by some a prevalent coexisting factor in appendicitis because it is most pronounced in adolescence, the age of the highest incidence of appendicitis. Many theories exist as to the causal relationship between lymphoid hyperplasia and appendicitis, but most depend on the fact that lymphoid tissue readily becomes the focus of infection. We shall not attempt to decide that causal relationship here, but in our group, with an average age of forty-four, lymphoid hyperplasia was still pronounced enough to be remarked upon by the pathologist in ten (14 per cent) of the appendices removed.

Our next consideration was whether obliteration of the appendiceal lumen, present to some degree in twenty-two of our seventy appendectomized patients, represented an aging process or repeated infection. We believe that scar tissue sufficient to obliterate the appendiceal lumen is most likely to be the result of repeated infection. Certainly the gut does not become obliterated with age, probably in part because it is not the site of repeated infection.

Few, if any, physicians will dispute the fact that periappendiceal adhesions and purulent exudate in the lumen, present in twelve of our patients, do not represent aging. They do, however, indicate the presence of former or existing inflammation.

Considering the above pathological findings, the thought may arise as to what is a normal appendix. It would appear that a "normal" appendix in the age group represented by our patients is a chronically diseased one. If the same criteria for inflammation are used in viewing the appendix as with other organs, it is readily discernible as a chronically and sometimes actively diseased structure.

However, since our patients were sick to the extent of having pelvic pathologic conditions requiring operation, and since we do not have information concerning the health of the appendix in normal healthy women of the same age group, not operated upon, dogmatic conclusions on this point cannot be stated. Nevertheless, the implication seems pertinent.

Why should the appendix be the site of repeated active and chronic inflammation? Logically, the answer lies in the anatomy and physiology of the organ. The appendix is a diverticulum of the alimentary canal and similar to the bowel in structure. Its muscular coats favor contraction toward the outlet. The appendix is suspended by its own mesentery, the mesoappendix, and is freely movable unless fixed by adhesions. Its blood supply, the appendiceal artery, is a terminal vessel, has no anastomatic branches and runs through the free mesentery of the appendix. The nerve supply is from the superior mesenteric plexus which also sends numerous twigs to the small intestine.

Appendicitis may occur as a result of occlusion of the lumen, either by a foreign body or by angulation of the appendix itself, and the presence of organisms distal to that occlusion. The structure of the appendix predisposes to these conditions. Whether appendicitis resolves by building up sufficient mechanical pressure to remove the obstruction and thus obtain free drainage, or goes on to gangrene and perforation, depends upon the degree and cause of obstruction and the virulence of the organisms. Furthermore, with repeated infection, the columnar mucosa, the muscular coats and blood supply become impaired by fibrous tissue change and the appendix loses some of its ability to overcome subsequent infection. If the patient lives long enough, the fate of the appendix may follow one of two courses. Either, because of re-

peated attacks which subside, it becomes a fibrous band without a lumen or, so long as the lumen remains, the appendix continues as a source of potential danger for an acute fulminating attack that can lead to gangrene, perforation and possibly death.

If the appendix is the site of repeated infection, why is it not more manifest clinically as acute appendicitis? The answer may lie in the nerve supply to the appendix. The nerve supply comes from the superior mesenteric plexus which also supplies the small bowel. As is well known, the early manifestations of appendicitis are chiefly generalized abdominal symptoms. In those that subside, these are the only symptoms. It is only in the acute fulminating case with involvement of the visceral, but particularly the parietal peritoneum, that pain and tenderness become localized to the right lower quadrant and all the signs and symptoms of acute appendicitis, as we know them, appear. Appendicitis, in a subclinical state, may, therefore, be a more common cause of generalized abdominal symptoms than is generally realized.

The mortality from appendicitis in the United States is about 5,000 per year. It's true that most of this mortality occurs in adolescents, though it is not necessarily confined to that age group. This death rate, plus the fact that we have no statistics on the number of people with perforations without death who may remain gastrointestinal cripples for the rest of their lives, nor any statistics on the morbidity and lost man hours in cases of appendicitis which subside, makes it seem that this is rather a high price to pay for an organ of no known function.

If, as the evidence suggests, the appendix is commonly a chronically and sometimes an actively infected organ, are we increasing the hazards to the patient by removing it at the time of major pelvic surgery? The 160 laparotomies for hysterectomy were divided into three groups: (1) those having an appendectomy at the time of pelvic surgery, (2) those who did not have appendectomies at the time of our pelvic surgery, and (3) those previously appendectomized at an earlier date. To compare postoperative morbidity, we did not use patients on whom routine appendectomy was not carried out, since they represented a sicker group and this generally was the reason why appendectomy was not performed. However, we took the two groups of patients, those on whom we performed incidental appendectomy and those previously appendectomized, and compared them. Seventy patients had appendectomies with pelvic surgery. Forty-eight had previously had an appendectomy.

Since the hazards of removing the appendix are primarily those of infection, we used the criteria shown in Table IV for comparison in these two groups.

TABLE IV. POSTOPERATIVE MORBIDITY

	Appendectomy With Pelvic Surgery	Appendectomized at Previous Date
Peritonitis or pelvic infection	0	2
Thrombosis or phlebitis	2	2
Wound infection	3	3
Delayed wound healing	3	2
Fever over 100° F. after 2nd postoperative day	7	7
Evidence of infection elsewhere	1	1
Total	16	17
Number of Cases	70	48
Percentage	23%	35%

We realize that other factors can account for these complications, but by using the same criteria for both groups and by assuming that other factors will be equal, we should obtain some idea as to whether appendectomy increased the postoperative morbidity. From our figures it would appear that appendectomy does not increase the postoperative morbidity. In fact, the converse is true, as the appendectomized patients filled these criteria in only 23 per cent, while those who had appendectomies previously filled 35 per cent. However, these figures must be cautiously interpreted. Perhaps some contraindication existed in the second group so that we would not have done an appendectomy anyway, and, furthermore, our second group contained more patients with chronic pelvic inflammatory disease. These, as well as other factors, doubtless influence these statistics. All we can assume, from these data, is that postoperative morbidity does not seem to be increased by the removal of the diseased appendix at the time of major pelvic surgery.

Conclusions

1. In the age group represented by the patients in our study, the appendix appears to be commonly a chronically and sometimes an actively infected structure.

2. We believe that if the abdomen is opened for other indications, the appendix, if present, should be removed, unless, of course, contraindications to so doing are present.

3. On the basis of this limited study, incidental appendectomy does not appear to increase the postoperative morbidity.

Chronic Urethritis in Women

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THE TROUBLESOME female urethra has long been a source of annoyance not only to the general practitioner but to the gynecologist and urologist, to say nothing of the patient herself. This annoyance has, in a multiplicity of cases, risen to the realm of a definite medical problem. All of us, despite our utmost endeavors, have found the pathologic condition and accompanying symptoms a problem, which puts a severe strain on the physician's medical knowledge and ingenuity, and often causes the patient much physical discomfort and mental anguish. Too many such problems have in the past been dismissed as a neurosis or as a menopausal complex.

The lesions of the female urethra are many, and it is the purpose of this paper to discuss only one phase of the affliction of that small part of the female urinary tract which may give rise to a symptom-complex so familiar to all of us.

The female urethra is a short tubular structure, 3 to 5 cm. in length, extending from the bladder to the vestibule. The external orifice is the narrowest portion, usually slitlike, but at times shaped as an inverted Y. There is a mucous, submucous and muscular coat. The epithelium is stratified squamous except near the bladder where it becomes transitional. There are many small tubular glands in the proximal one-third and a few lesser ones in the outer one-third. The submucous layer is areolar tissue with elastic fibers and a network of venous spaces. The muscular coat consists of two layers, longitudinal and outer circular. The inner portion of the latter forms the internal sphincter. The voluntary sphincter is a layer of striated muscle fibers arising between two layers of the triangular ligament surrounding completely the urethra and extending to the vesical outlet.

Numerous investigators have contributed to the literature as to the size, position and distribution of glands. Caldwell[1] found glands in nearly all posterior urethras and concluded that they were counterparts of the prostate glands in the male. MacKenzie and Sing[7] after serial section found in the anterior one-third and occasionally middle one-third peri-urethral tubular structures distinct from Skene's glands. Roeser and Kretchmer[10] called attention to Skene's glands as an often overlooked cause of urinary symptoms and stated that temporary relief by instrumentation by sounds or the cystoscope was often obtained as a result of the pressure of these instruments on the infected glands causing the expression of retained discharge. Maximov and Bloom[8] demonstrated within the epithelial lining of the bladder neck, intra-epithelial glands which do not cause the epithelium to bulge nor cause the basement membrane to project into the connective tissue. In a clinico-pathological study of 100 female urethras which showed no evidence of obstruction, Lentgen and Herbert[6] found glands in every case in the anterior urethra and in 65 per cent of the posterior urethras. Their most constant pathological finding in the female urethra was that of cystic degeneration, and they believed that it was difficult to eradicate because of the presence of these cysts in the transitional epithelium of the urethra. Hyperplastic change at the vesical neck in the female is frequently associated with marked urinary disturbance and pain, the diagnosis of which is based on careful urethroscopic investigation.

This anatomy in itself may be a predisposing factor in the presence of the pathologic condition under discussion. Winsbury White[12] experimentally injected India ink into the deep cervical tissues and demonstrated, by post-mortem serial section studies, lymphatic connections between the cervix, base of the bladder and the kidneys. The fact that the mere passage of a sound into the deep urethra, either in the male or female, may be followed by systemic reaction as a chill, fever and even renal tenderness, has undoubtedly been observed by all urologists. Before the advent of streptomycin, penicillin, and the sulfonamides, it was noted that operations about the bladder neck might be followed by renal sepsis, particularly when the operation was done to correct an inflammatory lesion.

Observation and treatment of pathologic conditions of the urethra and trigone have been greatly simplified by the almost universal use of the for-oblique lens which gives the observer a clear picture of the urethra and its analoge, the trigone. Cystoscopically, submucous injection of the trigone, the so-called trigonitis extending from the posterior

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vesical lip to one or both ureteral orifices, is seen to extend out into the urethra and should be interpreted as a lymphangiitis.

Factors contributing to chronic urethral lesions may be divided into three groups: (1) previous urinary tract infections, (2) genital tract infections, and (3) a combination of the first two. Rarely in our experience have we found a distant foci of infection to be responsible and none in the present series. In our first group it is noteworthy that 50 per cent of the patients date their symptoms from catheterization following surgery or delivery. Whether or not infection was introduced at that time, or trauma or carelessness was responsible, is impossible to decide. In our opinion the presence of a small meatus, necessitating meatotomy before a No. 24 F. pan-endoscope can be introduced, is definitely a predisposing factor. It further adds significance to the old adage as applied to the urinary tract that treatment of infection is of no avail unless obstruction is removed. Deakin[3] pointed out that no amount of urologic manipulation of the urethral mucosa may reasonably be expected to affect a permanent cure of a chronic urethritis so long as sagging of the bladder and the consequent angulation of the bladder and urethra persist. His experience was that electrocoagulation of areas of granulation tissue or of tabs in the urethra was followed in practically every instance by a most gratifying return to normal in the appearance of the mucosa, as well as by a relief from symptoms. Acute infections of the urinary tract, specifically pyelonephritis, concern us here only in that they may be precursors of chronic lesions.

In our second group the most outstanding contributing factor was a cervicitis. It has long been recognized that cervicitis and cystitis occur simultaneously. It has been the speaker's experience that it is a problem of great magnitude to convince some gynecologists that a low grade cervicitis can be responsible for a patient's urinary symptoms and that measures should be taken to correct what to the gynecologist appears to be an insignificant physiological entity. Pregnancy, abortion, gonorrheal infections and pelvic infections are very potent factors in the production of changes in the lower urinary tract.

Our third group presents a combination of the aforementioned and is particularly important from a treatment standpoint. Treatment of only the urinary lesions or only the gynecological lesions is only a temporary expedient and, while it may result in temporary relief of symptoms, does not eradicate the pathology. Thirty per cent of our cases had had previous gynecological surgery, which to some extent gave temporary comfort, but recurrence of symptoms sent them elsewhere for relief. Close co-operation between the urologist and the gynecologist is essential.

Very briefly, I should like to present some of the findings observed in sixty-eight cases which have come under our observation. The presenting symptoms of all were frequency, burning on urination, chiefly terminal, urgency and nocturia. As a rule these symptoms were intermittent, coming on suddenly in attacks, occurring from once a year in one instance to twelve times a year as the most frequent. The average duration of symptoms was eight years. The severity of the attacks had no relation to the frequency, and in only four instances did it coincide with or follow menstruation. It was felt that the two most common factors noted in each history were first, a gastrointestinal upset, and second, a more marked vaginal discharge than had been previously noted. In three instances Trichomonas vaginalis were found in the vaginal secretion, but none was ever recovered from the catheterized urine.

Symptoms were most marked when the patients were doing their daily work. Frequency and urgency were the chief complaints, the latter being so severe that incontinence was present in 8 per cent of the cases. Nocturia regardless of fluid intake was present in every case, varying from one time a night to every hour. Eight cases gave a history of hematuria, of which seven were terminal and associated with severe pain. Ten cases stated that they had lower abdominal discomfort, described as a bearing-down sensation. Forty-nine patients complained chiefly of burning on voiding or pain supposedly urethral in origin. Four complained of backache in one or both costovertebral areas. Forty-three of these patients were married, twenty-one, widowed or divorced, and four, unmarried.

On examination, forty (approximately 50 per cent) complained of tenderness of the urethra on palpation and were distressed by the passage of a catheter. Of the cervices examined, twenty-seven (40 per cent) showed definite evidence of infection. Eighteen patients had pelvic relaxations, of

which eight had been repaired. In all cases catheterized urine specimens were obtained, and in forty-four these were found to be crystal clear with only a few pus cells per high-power field. The remainder were found to have many bacteria and white blood cells with few to many red blood cells. Meatotomy was necessary in forty-three cases before a McCarthy No. 24 pan-endoscope could be passed. In only one case were we able to definitely diagnose a true stricture back of the obstruction at the meatus. One slight urethrocele was noted which had been repaired elsewhere. In this case the slight sagging of the floor was not thought responsible for her symptoms. She went elsewhere for dilation of the urethra after fulguration, and another surgeon operated on her for this condition for the second time, and he reported that her symptoms had been entirely relieved. Forty-eight cases received upper urinary tract work-ups, and in twenty-six of these we were able to obtain one of the following organisms from the bladder or from one or both kidneys: E. coli, ten; mixed organisms, nine; staphylococcus, six; streptococcus, one. Upper tract pathology must constantly be kept in mind and the following conditions were found: pyelonephritis in nineteen cases, nephrolithiasis in two cases, ureteral stricture in one, nephroptosis in three, interstitial cystitis in one.

Authors have differed as to the best method of treatment in these types of cases. Everett[4] describes a small series of cases where dilatation and instillation of $AgNO_8$ were of no avail. He believed that post-menopausal patients with vaginal and urethral findings were best treated with vaginal suppositories of amniotin. As an explanation of the pathology, Folsom[5] suggested that at the menopause the estrogen-androgen imbalance may cause a glandular proliferation. This, however, does not account for the symptoms presented far before the menopause. Cook[2] felt that fulguration of the urethra was of little value and that extensive treatment resulted in extreme inflammation and cicatrization. Spense[11] used fulguration of the entire mucous membrane followed by dilatation to No. 34 F. The writer, in conjunction with L. W. Riba and Frank Christensen[9] some years ago, working at Northwestern University Medical School, reported various lesions of the female urethra and our method of treatment. Following fulguration we dilated these cases to an average of No. 35 F.

At present our procedure, following the preliminary steps before mentioned, is to work up the higher urinary tract if there is any evidence at all that this might be the causative factor in bladder neck complaints. To our regret we have discovered that in three instances, upper tract pathologic conditions have been missed because we felt we did not have sufficient evidence to subject the patient to such investigation. We do a meatotomy when indicated, and a careful examination of the entire bladder and urethra is made with a No. 24 McCarthy pan-endoscope. All cysts and granulations on the urethra and trigone are fulgurated with a light current. This current is sufficient to cause blanching of the mucous membrane, but not strong enough to injure the musculature beneath. It is well known that any current will cause destruction or at least temporary injury to tissues which cannot be visualized so extreme caution is necessary in the degree of fulguration used. This maneuver is carried out rapidly and easily with the instrument mentioned. We have arbitrarily set a three-week period before any further instrumentation is done. Our meatotomy is usually generous so that we have as yet had no difficulty in introducing a No. 26 F. Van Buren sound on the first postfulguration visit. We have limited ourselves to gradual dilatations until a No. 30 F. is reached and have contented ourselves with this size, rather than go to the No. 35 F. by means of the Kollman dilator which we formerly believed necessary.

Our results have been most gratifying, yet we must admit that in private practice a complete follow-up has not been practical as when dispensary patients were investigated. In sixty out of the sixty-eight cases, almost complete immediate relief was noted. The remaining eight reported as follows: Two were slightly better, one unchanged, and five made temporarily worse by the fulguration. Of the sixty cases, forty-six had no recurrence of symptoms until sounds were passed which caused a recurrence of symptoms, lasting as a rule for forty-eight hours but in one case persisting for six days. The case of interstitial cystitis received temporary relief which we now believe due to bladder dilation under anesthesia, but her symptoms recurred in six weeks and were only relieved by fulguration of a small ulcer and bladder dilation. As yet, it is too early to consider our results in this case, but it is interesting to note that in the second cystoscopy the granulations were

no longer present in the urethra. Of the forty-six cases which had no recurrence, we have been able to follow only thirty-nine of them for one year with any accuracy. Sixteen (41 per cent) consider themselves completely cured, i.e., have had no recurrence of symptoms. Ten (25 per cent) state they have been markedly improved. Eleven (28 per cent) have been slightly improved, while two (4 per cent) have not been benefited. The latter have had but one cystoscopy and fulguration. In all cases, attempts were made to correct pathologic conditions outside the urinary tract.

1. A résumé of sixty-eight patients with chronic urethritis is presented.

2. With a careful history, physical examination and urinalysis, a pathologic urethral condition may be suspected.

3. The absence of gross and microscopic findings in catheterized urine in the female, together with a history of long standing vesical irritation, is an indication for a complete urological work-up with special attention directed to the urethra.

4. The detection and correction of urethral lesions which occur more often than is realized is a major urologic problem.

5. Our method of diagnosis and treatment of this condition has been presented.

6. It is suggested that suburethral chronic infection may be responsible for pathologic conditions in the higher urinary tract.

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Emergency Eye Care in General Practice

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OCULAR INJURIES constitute but a very small part of the multitude of conditions those in the general practice of medicine are called upon to treat. Because of their relative infrequency, however, the physician is often at a loss as to the proper approach in their managment. This feeling of hesitancy is heightened by the realization that improper care may cost the patient his eyesight. It is not always possible nor always necessary to refer these patients to those especially interested in eye care since most ocular emergencies can and should be cared for by those who first see the patient. Delay caused by sending the patient some distance to a specialist may in itself result in a poor outcome. With such a thought in mind, let us review some of the more common emergency ocular conditions and make some suggestions that may help in obtaining a good result.

Probably the most common eye condition seen in general practice is the corneal foreign body. In removing the foreign substance it is necessary to have adequate anesthesia, good illumination, and good magnification. Without these aids the operator is more than likely to scrape off a large area of corneal epithelium and thus add to the severity of the patient's injury. Adequate anesthesia is best obtained by drugs such as 1/2 per cent pontocaine, which does not soften the corneal epithelium and thus promote epithelial stripping, such as is obtained with cocaine. A Beebe binocular loupe and small pencil flashlight, together with an assortment of sterile foreign body spuds, complete the equipment. If foreign body spuds are not at hand, a small sterile hypodermic needle on a small luer will suffice. Many foreign bodies can be removed by simply brushing them off the cornea with a wet cotton applicator. It is necessary to remember that the charred tissue about the actual foreign body must be completely removed if the lesion is to heal. It is my practice to instill butyn-metaphen ointment and pad these eyes for

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a few hours following foreign body removal. If there is ciliary injection and the area of trauma in the cornea is hazy, uveitis and ulceration are probably present and the patient might better be turned over to your ophthalmologist. Foreign bodies imbedded in an area 6 mm. in diameter in the center of the cornea must be handled with great respect since this area is the optical zone of the cornea. Even faint scars of this zone will result in considerable permanent visual loss.

Corneal abrasions undoubtedly are next in order of frequency. These are often missed by the examiner if the abrasion is not stained with 2 per cent aqueous fluorescein. Abrasions usually heal readily in a day or two by instilling some combination ointment such as butyn-metaphen or metacaine-merthiolate and tightly padding the eye.

Blunt, nonperforating, contusive injuries to the eyeball are rather frequent among children. Fortunately the protection afforded by the bony orbital rim prevents most of these injuries from doing serious harm. The plebian black eye is best treated, if seen immediately, by applying continuous ice compresses. This will largely control the edema. Hot wet compresses may be preferred if the process is seen later when edema is present. The heat will merely hasten the absorption of blood. If it is necessary for the injured individual to make a public appearance, the discoloration of the lids may be masked by the use of the cosmetic labeled "Cover Mark," which may be secured from any beauty parlor.

Contusive injuries to and about the eye should not be passed over lightly, however, until the orbital rim and interior of the eye have been thoroughly searched for more serious damage. Fractures of the orbital rim showing considerable displacement may result in displacement of the eyeball and disturbances in its motility. Such displaced fractures should be replaced at once or as soon as the edema has subsided.

A subluxated lens, resulting from contusion, will not respond to treatment, but by discovering its presence embarrassment to the examiner may later be avoided. The same is true as regards vitreous hemorrhage or ruptures of the choroid. When the latter conditions are found, the eye should be watched for development of retinal detachment. Should detachment of the retina occur, immediate ophthalmological care is imperative.

Blunt injuries to the globe not infrequently are followed immediately or later by massive anterior chamber hemorrhage. The complication is one which requires careful observation, and unless you are sure of your grounds, you might better shift the responsibility to an ophthalmologist. Most anterior chamber hemorrhages will absorb fairly readily with the use of 1 per cent eserine or 2 per cent pilocarpine four times daily, together with hot compresses. Others may persist or result in a secondary rise in intraocular pressure. Since this pressure, in the presence of anterior chamber hemorrhage, leads to the development of blood staining of the cornea, the increased pressure must be relieved immediately by corneal paracentesis. The use of eserine or pilocarpine will have no influence on the pressure, and valuable time should not be lost in trial. I have yet to see an eye showing blood staining of the cornea which eventually obtained useful vision. I have not seen blood staining of the cornea result from anterior chamber hemorrhage when there was no increased ocular pressure. These two observations emphasize the necessity for early recognition and correction of the glaucoma in this type of ocular trauma.

The anterior chamber hemorrhage from blunt nonperforating contusion to the eyeball often results from lacerations of the iris. The weakest part of the iris is its attachment to the ciliary body. Laceration of the iris at this point results in a pulling away of the iris at its base. If this is severe the pupil is usually strongly displaced towards the opposite side. Slight to moderate displacement of the pupil gives no visual impairment, but marked pupillary displacement gives marked loss of vision. These latter cases indicate the need of surgical correction.

Perforating injuries to the eyeball by flying particles point to the desirability of x-ray of the globe. X-ray of the eye should be done in all instances in which the history suggests the possibility of an intraocular foreign body. Many of these eyes have an obvious perforation of the globe, but in others careful search reveals no point of entrance. An undiscovered intraocular metallic foreign body may give no symptoms for years. More commonly they result in recurrent iridocyclitis, endophthalmitis, cataract, or siderosis bulbi. Once the retained foreign body has rusted away and the rust disseminated through the eyeball, the globe goes into phthisis. Those physicians connected with industrial first aid stations or those not especially interested in eye care should not burden

themselves with the responsibility of caring for these patients. A fairly high percentage of enucleations eventually follow perforating ocular injuries.

With the advent of relatively inexpensive ultraviolet lamps, their use in the home is becoming more common. The users of these lamps sooner or later become careless and do not adequately protect the eyes while taking a sun bath. Since the eyes are sensitive to infrared and ultraviolet rays nearest to the visible spectrum, we occasionally see these people with violent edema, photophobia and pain. No permanent damage is produced by this severe reaction, but adequate care is needed to give comfort. Ice compresses, dark room, and the instillation of phenocaine-epinephrine ointment (Upjohn) will give almost complete relief. Arc welders and electricians receive similar types of electric ophthalmia.

There are many types of chemical burns involving the eyes, and, in general, they are to be considered as serious. The alkalies are usually more damaging than the acids in that they have a tendency to keep on working deeper and deeper into the tissues while the acids coagulate the proteins of the surface cells and thus produce a more superficial lesion. Cicatricial contraction of the conjunctiva results in symblepharon of varying degrees.

The first treatment is the most important. Speed and thoroughness are the main requisites for a satisfactory end result. Chemical burns should be treated immediately by copious washing with tap water. The more water used, the better. Care must be used to evert the eyelids no matter how serious the blepharospasm. Only too frequently the plaster, lime or other chemical is left in the retrotarsal folds to act over a long period of time. No attempt should be made to neutralize an acid with an alkali, et cetera. Adhesions should not be allowed to form between bulbar and palpebral conjunctiva. By passing a small smooth glass rod covered with vaseline between the lids and globe once or twice daily symblepharon may be prevented.

Lacerations involving the margin of the eyelid require immediate and accurate repair if cosmetic defects and functional disturbances are to be avoided. Most of the textbooks on ophthalmic and plastic surgery deal with methods of correcting the late deformities which result from lacerations of the eyelids. More emphasis should be placed on methods of preventing deformities resulting from recent lid trauma. The physician who first cares for these patients has the best opportunity of giving a good cosmetic and functional lid. Lack of appreciation of this fact often results in hasty and bungled repairs which later have to be reoperated upon with less chance of a satisfactory result.

Lacerations of the eyelids may be of relatively minor importance compared with the shock and other more serious trauma which the patient may have coincidently. Rather than make hasty and inadequate repairs under these circumstances, the eyeball should be covered, if exposed, and the repair of the lid lacerations left until a time when more meticulous care can be expended on their suturing. The longer the interval between injury and repair, the more edema is present. This edema distorts the tissues of the lids and, to some extent, complicates the surgery. If ice compresses are kept on the lids until the surgery can be started, much of the edema can be prevented.

Extramarginal lacerations require more care than do lacerations elsewhere on the body surface. It is necessary to recall that there is very little tension on the tissues of the lids, and therefore much finer sutures and needles should be used to give the least possible scar. Use 6-0 black silk with atraumatic needles for all skin and conjunctival repairs of this type. No silk or gut sutures or knots should ever be allowed to come into contact with the cornea from the inner surface of the lid. For proper lid action it is imperative that extramarginal lacerations severing orbicularis muscle bundles be reunited as a layer. This is best done with 5-0 mild gut sutures on atraumatic needles. When the levator tendon is severed, it should be isolated and sutured with 5-0 medium gut to prevent ptosis. It is far more difficult to make this correction in a healed deformity. If meticulous cleansing of the wound is carried out, no drainage tubes need be inserted. Only crushed tissues are excised.

Transmarginal lid lacerations, on the other hand, require even more meticulous repair if the results are to be both cosmetic and functional. Here again we must stress the need for using the fine sutures and atraumatic needles and the least debridement possible; 6-0 silk is used on the skin surface, and 5-0 or 6-0 gut is used for the buried sutures.

The most important suture (Fig. 1) to be placed is that uniting the intermarginal groove. This is the grey line situated between the openings of the

Meibomian glands and the eyelashes. If the first suture placed passes through this line down into the substance of the tarsus and then across the line of laceration to enter the tarsus at the same

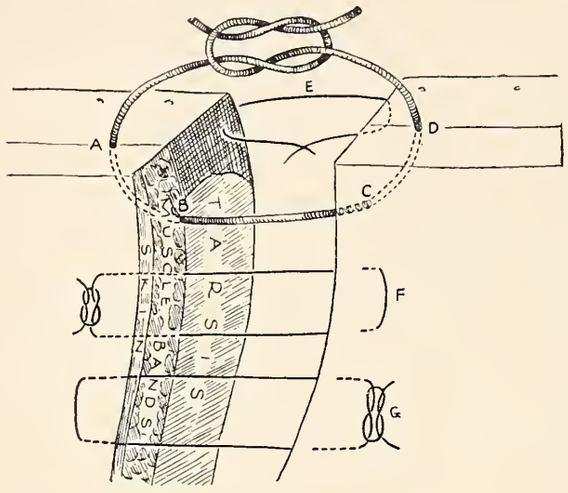


Fig. 1. Transmarginal laceration of lower eyelid. (A, B, C, and D) points of entrance and exit of suture uniting intermarginal groove; (E) deep buried gut sutures uniting tarsal plate; (F) sutures uniting orbicularis muscle bundles, either buried or not; (G) cuticular sutures.

distance from the lid border and comes out in the intermarginal line on the other side of the laceration, the lid border will be in perfect alignment. This enables us to insert accurately the deep buried gut sutures closing the tarsoconjunctival surface and the superficial silk sutures closing the orbicularis muscle and skin. Silk or gut sutures or knots should never be left in contact with the corneal surface, since the movement of the globe will cause abrasion and scarring.

Minsky[1] has made helpful suggestions which aid in obtaining smooth union of the lacerated lid border. He splints the two lid borders together by passing the sutures uniting the lacerated lid margin through the opposite contacting lid border and then brings the sutures out through the skin above the lashes; tying them over a rubber plate. Where more than one laceration of the lid border is present this splinting suture method of Minsky may be utilized with advantage. Should the transmarginal lid laceration involve both lids at the same point, Minsky's figure eight suture[1] may be used. This gives perfect alignment and splinting of both lid borders. The deep buried conjunctivotarsal gut sutures and the superficial musculocutaneous silk sutures are inserted as previously mentioned.

Special precautions are necessary when lid lacerations involve the lateral or medial canthus. Should the lateral canthal ligament be severed or evulsed, the lids are not held tightly against the globe and epiphora and ectropion will result. It is therefore necessary to see that strong 4-0 gut sutures unite

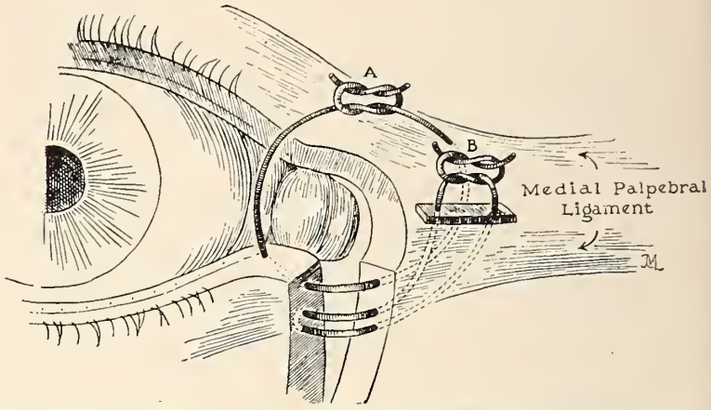


Fig. 2. Laceration of eyelid at inner canthus, severing lower lacrimal canaliculus. (A) heavy chrome gut suture threaded through the canaliculus and into the lacrimal sac, coming out through the skin at the upper pole of the sac; (B) traction suture anchoring severed lid to the internal palpebral ligament. Deep conjunctival gut sutures, orbicularis muscle sutures and skin sutures inserted in layers to close remainder of lid defect.

the severed ends of the ligament. Should there be tissue loss and the ligament not identified, the outer ends of the tarsal plates should be united by sutures with the periosteum behind the lateral orbital rim at the point conforming to the lateral canthus. The orbicularis muscle fibers near the lid border should be included in the cutaneous sutures, since these muscle fibers play an important role in keeping the lid border from turning out in ectropion. The intermarginal sulcus is again utilized in lacerations at the lateral canthus, since a suture passed through this line below the canthal laceration and then across the laceration to come out in the intermarginal sulcus of the other lid will perfectly reform the canthal angle.

Lacerations and evulsions of the medial canthus involve even more important anatomical structures, since only too commonly the lacrimal passages are severed. Unless the medial canthus is properly restored and the lacrimal passages remain patent, troublesome epiphora results.

When the laceration goes across the lower canaliculus, a heavy chromic catgut suture is threaded through the punctum and canaliculus and through the medial cut end of the canaliculus and into the lacrimal sac (Fig. 2). The needle is brought out through the upper pole of the lacrimal sac and through the skin above the internal palpebral ligament and tied.

It is necessary to anchor the inner end of the severed lid to the internal papebral ligament or

periosteum. This is best done by passing a double armed No. 2 braided silk suture through the conjunctival surface of the torn lid to come out below the severed canaliculus. These sutures are then passed through the torn medial lid tissues below the canaliculus and directed upward to engage the canthal ligament in an attempt to anchor the lid at this point. These sutures are brought out through the skin and tied over a rubber plate (Fig. 2). The skin and orbicularis muscle are united in layers after the depth of the wound is closed with buried gut, as in the transmarginal lacerations.

Summary

Ocular injuries should receive immediate meticulous care. The majority of such injuries can and should be the responsibility of the physician first seeing the patient. The simplest of ocular trauma may result in loss of eyesight, but this can usually be prevented by following a few simple rules of ocular care. Lacerations of the lids cannot be sutured in the same manner as simple lacerations elsewhere on the body surface. The peculiar and complex anatomy of the eyelids must be maintained if function is not to be disturbed.

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MSMS

MORE MEN AND BOYS DROWN

While women's deaths by drowning increased more than 50 per cent in 1947, the fact remains that nine out of ten people who drown in Michigan are men and boys.

There were thirty-nine women and girls among the 307 persons who drowned in Michigan in 1947. There were twenty-five women and girls among the 265 persons who drowned in the state in 1946.

Two-thirds of the drownings in the state occurred during the three summer months, June, July and August. However, the larger share of deaths during these months did not occur at swimming beaches and nearly as many occurred in rivers as in lakes.

Lakes took the lives of ninety-seven persons; rivers, eighty-three persons; boating accidents, forty-three persons; and quarries and miscellaneous places, eighty-four persons.

Nearly half of the river deaths were of children under fifteen years of age. Lake deaths were about equally divided among those over and under twenty-five years of age. Boating accidents were concentrated in the fifteen to forty-five years age group. Twenty-three of the thirty-nine women and girls who drowned were under fifteen years of age.

Diagnosis of Early Uterine Cancer

By Harry M. Nelson, M.D.
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THERE HAVE BEEN no recent developments in cancer treatment. The emphasis today is on early diagnosis, to find the lesion at the very start when it is almost always curable by surgery, x-ray or radium. This is true of all cancer. Since we can discover cancer of the uterus early and relatively easily, it becomes possible, even without improving present methods, to cure most cases. Cancer of the uterus was responsible for 17,152 deaths in the United States, 710 in Michigan, during 1945—a death rate which indicates that there has been no appreciable decline in recent years. It is estimated that 62 per cent of all cancers occurring in women are in the breasts, pelvis, skin or rectum. Periodic physical examinations, by a physician on the alert to recognize early signs of cancer, should reveal most suspicious or early lesions in these areas without any special diagnostic aids. This indicates that routine annual or semiannual examinations in all women over thirty is an ideal goal in preventive medicine, though difficult to obtain.

Late diagnosis is the basic reason for failure in curing uterine cancer. This may be due to the physician's indolence or to the fear, ignorance and the natural inclination to procrastinate on the part of the women. The American public has, however, been aroused as never before to the danger of cancer and the need for seeking periodic examinations and aid at the earliest sign of danger. The doctor must do his part. Physicians have in the past approached the problem of periodic examinations without enthusiasm, because they have associated applicants too often with introspective, neurotic and apprehensive individuals. Because of the cancer educational work throughout the nation, we may expect to encounter more and more patients requesting periodic examinations who are genuinely interested in cancer diagnosis and prevention. These patients will seek physicians who are sympathetic to the problem and willing to give the deliberate and painstaking examination the public is being educated to expect. Routine examinations for well persons and cancer detection centers are

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part of the educational program of such organizations as the American Cancer Society. These clinics or centers focus the attention of women on the importance of periodic examination. They will eventually, we hope, make every doctor's office a detection unit. If every woman had a competent examination every six months with proper treatment when indicated, the mortality due to cancer of the uterus would take a spectacular drop.

Etiology

Most statistical studies indicate that carcinoma of the endometrium is much less frequent than carcinoma of the cervix; it was formerly estimated at twenty to one. In our hospital there is one carcinoma of the endometrium for every 3.45 of the cervix.

TABLE I. INCIDENCE OF CARCINOMA OF THE FUNDUS UTERI AND CERVIX UTERI, 1935-1946

	Number of Cases	Incidence Per Cent
Adenocarcinoma of fundus uteri	98	22.05
Adenoacanthoma of fundus uteri	2	.45
Squamous cell carcinoma of cervix uteri	318	71.5
Adenocarcinoma of cervix uteri	26	5.8
Total	445	100.00

Ratio of Carcinoma of Cervix to Fundus Uteri, All Ages, 3.45 to 1
Woman's Hospital, Detroit, Michigan

However, the Connecticut studies in a large series of cases show that endometrial carcinoma is much more frequent, the incidence there being three of the cervix for every two of the endometrium. Cancer of the cervix reaches its peak between the ages of forty and forty-five. Hence, it usually comes before, not after, the menopause. Though cases are found in elderly women and rarely in childhood, the highest index of suspicion should be held with respect to women in middle life, between the ages of thirty and sixty. Endometrial carcinoma is a disease that occurs most frequently during and after the menopause, the average age being about fifty-six years.

While the cause of cancer is unknown, there is some evidence that it may be an intracellular rather than an external factor. In many cases, a genetic factor and hormonal disturbances may be the predisposition which permits chronic irritation (external factor) to set off the uncontrolled growth. Gynecologists have taught for years that chronic irritation of the cervix predisposes to carcinoma. It is questionable whether pregnancy or labor plays any part in the development of cancer of the cervix. However, it is felt that the correction of common lesions of the cervix by conization, cauterization or amputation is a prophylaxis against the disease. In other words, cancer does not seem to occur commonly in the healthy cervix.

It probably is not possible to produce carcinoma of the uterus by means of estrogen treatment; at least, there are no authenticated case reports in the human being. It is known, however, that the estrogens do have carcinogenic effects in some animals and tissues. Since there is this uncertainty, estrogen therapy should be used very carefully or not at all in patients who have hereditary or other factors which might act as a predisposition to the disease. No patient should be given estrogens who has not had a careful examination. Delayed menopause is an indication of aberrant endometrial activity and a warning of a tendency to endometrial malignancy.

Symptoms

The most important symptom in history taking is the type of abnormal discharge. Cancer of the cervix is a particularly treacherous disease. In its early and curable stage it may cause little or no symptoms which may direct the attention of the patient or her physician to the condition. The three chief symptoms are leukorrhea, bleeding and pain, occurring in the order named. The vaginal discharge at first may differ from the normal vaginal secretion only in quantity. It may be a watery, serous or purulent discharge. Later, it may be somewhat bloody and of a characteristic watery consistency. Bleeding is usually the result of erosion of capillary blood vessels by the new growth, or it may be the result of trauma and follow intercourse, vaginal douching or vaginal examinations. A long history does not necessarily mean an advanced lesion, nor a short history an early one. Extent of the lesion depends more on the type of cancer than on the length of time. Pain, unfortunately, is a relatively late symptom and is, therefore, of little value in arriving at an early diagnosis.

In carcinoma of the endometrium, the menstrual cycle may be longer and the amount of bleeding greater. The menopause may be delayed, or an abnormal amount of bleeding may occur at this time. The appearance of spotting or irregular bleeding in the postmenopausal woman is always suggestive of cancer. Uterine hemorrhage in a woman beyond the menopause is positive evidence of cancer until thorough examination demonstrates conclusively that no malignancy is present.

In a recent study of 369 consecutive case histories of women, forty-nine years of age or older,

TABLE II. ABNORMAL VAGINAL BLEEDING IN WOMEN PAST AGE FORTY-NINE—MALIGNANT LESIONS

Location of Lesion	Number of Cases	Incidence Per Cent
Carcinoma of cervix	68	55.7
Carcinoma of corpus	42	34.5
Carcinoma of ovaries	4	3.3
Carcinoma of vagina	5	4.1
Pseudomyxoma Peritoneii	1	0.8
Carcinoma of vulva	2	1.6
Total	122	100.0

Ratio of carcinoma of cervix to fundus uteri past age 49, 1.6 to 1
Woman's Hospital, Detroit, Michigan

TABLE III. ABNORMAL VAGINAL BLEEDING IN WOMEN PAST AGE FORTY-NINE—ALL LESIONS

Type of Lesion	Number of Cases	Incidence Per Cent
Malignancy	122	33.0
Persistent Proliferative Endometrium	56	15.2
Atrophic Endometrium	34	9.2
Endometrial Polyps	41	11.1
Cervical Polyps	11	3.0
Leiomyomata Uteri	42	11.4
Cervicitis	20	5.4
Miscellaneous	43	11.7
Total	369	100.0

33% of all patients over 49 entering hospital because of bleeding had cancer.
Woman's Hospital, Detroit, Michigan.

who were admitted to Woman's Hospital because of abnormal vaginal bleeding, there were 122 cases of malignancy, representing 33 per cent of the total series. The possibility of a corpus carcinoma should always be suspected in menopausal or postmenopausal women seeking advice for symptoms produced by fibroids of the uterus.

Examination and Diagnosis

In practically all cases the cause of bleeding can be definitely established by a careful history and thorough pelvic examination, curettage and microscopic examination, assuming, of course, that there is no extra-uterine pathology evident. Over 90 per cent of the cases of cancer of the cervix can be diagnosed by the physician who does a bimanual examination, a careful inspection, and takes biopsies of any suspicious lesions. It is not enough to examine the pelvis only when symptoms arise. A careful bimanual examination should be part of every physical examination.

The inspection of the cervix should be carefully and properly done. There must be satisfactory exposure and adequate illumination. A good speculum examination is possible in most instances because the majority of patients have a marital outlet. Vaginal inspection must be made with deliberation and according to plan. If abnormal bleeding is present, the blood may be seen coming from the cervical canal, in which case a diagnostic currettage is definitely indicated to determine the presence or absence of intra-uterine or intracervical pathology.

The diagnosis of frank cancer of the cervix is easy. At first it is a small, red, irregular, elevated, circumscribed growth situated at, or near the external os, which when touched with a pointed instrument, such as a probe, penetrates and bleeds readily. To the palpating finger, the area feels slightly raised, granular and somewhat indurated or hard.

Unfortunately, there is no gross picture that is pathognomonic of the very early cervical cancer. Diagnosis of cervical carcinoma which is pre-invasive or so-called carcinoma *in situ* is often very difficult. There is no typical gross appearance of the earliest lesion before ulceration. It may be a very small hard area or it may look like a polyp. Any of these areas should be excised for microscopic examination. Naked eye study remains the most dependable method in the recognition of questionable areas which may require biopsy. Get a biopsy in a patient with postcoital bleeding even though the cervix appears normal. It has been often shown that cellular changes develop in the surface stratified squamous epithelium of the vaginal portion of the cervix which are regarded as the early manifestations of malignant transformation. That these changes occur before there is clinical evidence of carcinoma has been demonstrated many times. The epithelial cellular changes are similar in non-invasive and early-invasive carcinomas in areas not yet frankly or clinically carcinomatous, and closely resemble the changes found in the epithelial cells of frankly or clinically carcinomatous lesions.

We recently presented fifteen cases of intra-epithelial carcinoma of the cervix. The removal of the cervix with the body of the uterus disclosed most of these cases. The cure rate should be 100 per cent. Such cancers are rarely recognized except microscopically. It illustrates the importance of frequent biopsies and vaginal smears. Since the above study, we have, in a large series of vaginal smears, been able to diagnose several cases of non-invasive carcinoma. Biopsy showed the intra-epithelial lesion. Treatment has certainly cured these individuals. Non-invasive cancer of the cervix may be latent for years; then, for some unknown reason the growth appears to be accelerated and the cancer becomes infiltrative. Before doing a hysterectomy for a diseased uterus, a pelvic examination under anethesia, biopsy of the cervix and

curettement should be done as indicated. A complete hysterectomy is advisable in most cases.

Biopsy

There are several ways of obtaining a biopsy. It is usually taken with a knife; a wedge shaped piece of tissue is excised and should include the growth or suspicious area with some of the normal cervical epithelium. The Burnam biopsy forceps is an excellent instrument for taking biopsies in the office. Bleeding from taking a specimen is usually transient, but if prolonged unduly, can be checked by cauterization or a small pack. Every suspicious area in the cervix should be biopsied. It is a simple easy office procedure, and should be used much more often.

In most advanced cases, tissue taken from any part of the new growth will show cancer on microscopic examination. Even in cases showing obvious carcinoma in the gross, biopsy is important to show the exact type of lesion.

A careful and thorough curettage is the ultimate method in diagnosis of cancer of the endometrium. A small curet that will reach the cornu of the uterus should be used, but with great care. While the so-called "office curettage" may be satisfactory for women with a patulous cervix, the best procedure is thorough scraping of the entire uterine cavity with the patient hospitalized and under anesthesia. Such thorough examination of the uterine cavity may reveal a small well-circumscribed neoplastic lesion, which may easily have been missed by less thorough examination.

The possibility of endometrial carcinoma should be borne in mind in every woman over forty with intermenstrual or postmenopausal bleeding. The one exception to curettage is pyometra. If pus is encountered, the cervical canal is dilated and nothing further done until the infection has subsided; then a thorough curettage is performed.

If you have available a fully competent cytologist who can interpret vaginal smears, this method of diagnosis may be used, particularly as a screening examination in women who come for periodic examinations. The vaginal smear method depends upon the recognition of single malignant cells cast off from the tumor into the vaginal secretion. As stated by Papanicolaou, the smear method should be used as a preliminary or sorting procedure and should be confirmed as a matter of routine by biopsy and tissue diagnosis. There is no doubt that when smears are examined by experts, a very high percentage of correct diagnoses can be made.

Unfortunately, the vaginal smear method has had too much publicity in the public press. It is true that an expertly examined smear might reveal evidence of cancer when no lesion can be seen on inspection, but even then one would not subject the patient to cancer treatment without a positive biopsy. In those cases where a suspicious lesion is found, it is the biopsy and not the smear which is the important procedure. It may not be too long until every well organized hospital or cancer center has a cytologist competent to pass judgment on specimens sent in.

Conclusion

The problem, then, is to educate all women that if they wait for irregular bleeding and unusual vaginal discharge to appear before presenting themselves for a physical examination, they are likely to wait too long. Physicians must include a vaginal examination of every woman as a routine procedure. Simple abnormalities of the cervix such as erosions, ectropion, polyps, lacerations and leukoplakic areas should be eradicated by proper treatment. Patients suffering from cancer must be given prompt and adequate treatment.

The excellent chance of cure in early cancer of the uterus diminishes rapidly with invasion of surrounding tissue. Unfortunately at the present time, over 70 per cent of all cancers of the cervix are in the advanced stages before treatment is started. There is very little hope of permanent cure in such cases, but palliative x-ray and radium treatment may lengthen life expectancy, relieve pain and discomfort, and occasionally cure the patient.

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MSMS

The average length of life among the Industrial policyholders of the Metropolitan Life Insurance Company reached a new peak of 66.5 years in 1947. This is one year greater than the corresponding figure for 1946. In the decade since 1937 the average length of life among these insured has increased almost six years, and in the past two decades the gain has amounted to more than ten years. Practically twenty years have been added since 1911-1912, when the average was only 46.6 years.—*Statistical Bulletin*, Metropolitan Life Insurance Company, August 29:5, 1948.

The Climacteric and Its Management

By Howard H. Cummings, M.D.
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THE FUNCTION of reproduction in the human female gradually declines in the latter part of the fourth decade and usually is completely lost in the early part of the fifth decade. During this period of time, menstruation occurs at lengthening intervals and in lessening amounts until it ceases entirely. Accompanying the gradual cessation of menstruation, atrophic changes occur in the external and internal generative organs. These atrophic changes, which are easily demonstrable, markedly affect the ovaries, thereby causing a temporary imbalance of the endocrine glands. The ovaries play the leading role during a woman's reproductive life, assisted by the pituitary gland and possibly the thyroid and adrenal glands. While our knowledge of the part that each gland plays is still incomplete, there is scientific proof that the close inter-relation of the endocrine glands is disturbed when one gland is impaired in its function. In time nature re-establishes a satisfactory endocrine balance.

This critical period in a woman's life—when the power of reproduction is lost and menstruation gradually ceases, when atrophic changes take place in the generative organs and the endocrine glands are thrown into a state of imbalance—is designated as the climacteric. The term *menopause* is frequently used by both physicians and laymen to designate this period of time and change, but scientifically it is not correct. Literally, menopause describes only one prominent objective sign of the climacteric. By usage, however, the two terms have come to be accepted as synonymous.

The multitudinous symptoms experienced by women during the climacteric are difficult to explain on the basis of an endocrine imbalance alone, but when disturbances of the autonomic and peripheral nervous systems are reviewed in relation to endocrine crises, the explanation of the symptoms of the menopause becomes clearer. As a matter of fact, the most prominent symptoms of this period fall into two groups: first, psychic symptoms; second, disturbances of the autonomic and peripheral nervous systems.

Under the heading of psychic disturbances are emotional instability, melancholia, weeping, morbid worrying, insomnia, fatigue, self-depreciation, self-accusation, jealousies, suicidal thoughts, lack of concentration, and impaired memory.

Common symptoms attributed to disturbances of the autonomic and peripheral nerves are hot flashes, chills, attacks of sweating, palpitation, dyspnea, vertigo, headaches, paresthesias, pruritus, and hyperesthesias. These lists are far from complete, but they do enumerate the most frequent symptoms of the menopause.

It would be simple for the physician, when confronted by such an extensive and complicated symptom-complex as the patient relates, to explain all of the disturbances on the basis of menopausal changes. However, during this same period numerous diseases may appear and in their several courses produce all of the symptoms mentioned. The degenerative and metabolic diseases, such as arteriosclerosis and hypertension, cardiac and kidney diseases, diabetes, obesity and anemias, develop during the forties and fifties. Malignancies and benign tumors of the pelvic organs frequently appear. Menstrual disturbances, especially menorrhagia and metrorrhagia, often occur. Thyroid deficiencies or hyperactive states are seen during the climacteric, and neuroses and psychoses can often make their initial appearance or recur at this critical time. These facts make it imperative when women complain of supposedly menopausal symptoms that physicians record complete histories and make thorough examinations.

The medical management of the woman in the climacteric may be very simple, or it may require all of the physician's resourcefulness, skill and judgment. Not all women require medical attention during this period of life. There is a wide variation in the statistics on this important question. Norris estimates that 90 per cent of healthy women go through the climacteric without experiencing any symptoms which interfere with general health or domestic and social activities. A contrary view is expressed by Hawkinson, who estimates that 75 per cent of all women experience

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distressing symptoms during the climacteric. Estimates similar to Hawkinson's in this country range from 65 to 85 per cent. But all statistics dealing with the frequency of disturbing climacteric symptoms are only estimates. No accurate figures are available. Nevertheless, physicians who are consulted by women in this age group know that a large proportion of these have distressing symptoms attributed to the climacteric.

The picture of the menopause is beclouded in the minds of many women by superstitions and old-wives-tales. Among the most common misconceptions are that the sexual life of the woman ceases at the menopause, that her usefulness to her husband and family is largely ended, that numerous and fatal diseases will attack her, and that the climacteric and senescence are synonymous.

Many times the only medical attention required by these patients is a reassuring consultation in which misconceptions are cleared away, and in which the physical changes taking place and causing the syndrome are explained. But this consultation should be delayed until the physician has satisfied himself by a careful history, a thorough physical examination, and all of the clinical tests necessary that disease is not present and causing the symptoms.

Knowledge of psychology and psychiatry is often essential to the successful treatment of patients in the menopause. No group makes more demands upon a physician's time or requires so much reassurance and personal encouragement. In fact, many cases with predominating psychic symptoms need the attention of the psychiatrist. True psychoses appear and self-destruction may occur when women develop mental depression, groundless suspicions and jealousies, lose interest in their normal activities and accuse themselves of uncommitted and unpardonable sins. Patients who develop involutional melancholia—an exaggeration of the menopausal complex—with suicidal tendencies should be treated in institutions by trained psychiatrists.

Most women in the climacteric suffer from relatively mild symptoms. In order of their frequency, Hawkinson lists the symptoms as follows: nervousness, menstrual disturbances, flushes and chills, excitability, fatigue and lassitude, depression, irritability, insomnia, tachycardia, vertigo, decreased memory and concentration, headaches, frigidity, numbness, tingling, and sweating. Fortunately, most of these symptoms may be alleviated or banished entirely by modern hormonal therapy.

Many estrogen preparations are available to the physician today. Most of them are effective. Each practitioner has favorite preparations and methods of administering them. Individual differences in response to drugs make it necessary to try out varying dosages. All of these drugs fall into one of three groups: first, natural estrogens (estrone, estradiol); second, synthetic (diethylstilbestrol, hexestrol, benzestrol); third, chemically modified natural estrogen to increase their effectiveness by slowing down the rate at which they are absorbed. For this purpose natural estrogens are combined with benzoic propionate or palmitic acid. Solid estrogens in pellets and crystalline forms when injected under the skin or into muscle will likewise delay absorption.

Time and experience have served the medical profession well in evaluating newer methods of treatment. This is especially true of estrogenic therapy in the climacteric. Medical opinion today concerning the use of the estrogenic drugs in the management of the menopause is not unanimously in favor of them, but some generally accepted ideas and methods are now well established and extensively followed.

The estrogenic hormones obtained from natural sources are known to be well tolerated by women whether given by the oral, subcutaneous, or topical routes. However, they are expensive and when used for months or, as sometimes happens, for several years, they cause an economic burden on the patient. Yet the synthetic estrogens, though just as effective in producing favorable response, are more irritating and toxic, but because they cost less they are available to all women needing them. Nausea and vomiting, which are the most common ill effects of the synthetic preparations, may be overcome by small doses given with food or upon retiring, or by omitting the drug at intervals, also by sedation accompanying the medication. When the natural or synthetic estrogens are suspended in oily media for hypodermic use and are given by this method, local irritations sometimes occur. Skin sensitizations and general allergic manifestations may also be produced.

In beginning treatment with estrogenic agents, the dosage should be sufficient to alleviate the symptoms or to cause their prompt cessation. Too

small doses will make the patient lose confidence in the efficacy of the drug. Large doses, however, should not be continued; rather they should be reduced as rapidly as possible to a point where the subjective symptoms are held in abeyance. From time to time, for short intervals, the medication may be stopped to test the patient for recurrence of the symptoms. Caution should be used, however, not to stop estrogen treatment suddenly or for too long a period of time. A sudden withdrawal of these drugs will produce uterine bleeding. Overdosage with estrogen may likewise bring about troublesome bleeding. When this occurs in women who have ceased menstruating, the physician is faced with the diagnostic problem of ruling out malignancy of the uterus. Frequently a diagnostic curettage is necessary to answer this question.

No definite plan of estrogen therapy can be given, for each woman reacts in a different way. Most women in the menopause show exacerbation of symptoms in monthly cycles, or at gradually lengthening intervals. Medication may be increased and decreased to meet these cycles. During the early period of treatment it is preferable to have the patient visit her physician for consultation and reassurance. A hypodermic injection of a crystalline preparation may be given at the time of the office visits. In certain cases these treatments may supplement oral administration. The various estrogens, whether natural, synthetic, or chemically combined, which may be taken by mouth make up the most generally used and most valuable drugs for treatment of the climacteric. Once the proper dosage is established, the oral route is most convenient for both patient and doctor. Patients using these drugs, however, should have constant medical direction throughout the whole time of treatment. Physicians should gradually withdraw these drugs and warn their patients not to resume taking them without medical advice.

Are there any contraindications to the use of the estrogens in the climacteric? Women who have malignancies or have had previous treatment for malignant disease should not be given estrogenic therapy. There is one exception to this almost inflexible rule. Older women with advanced malignancies and metastases in the soft parts of the body obtain palliative relief from their suffering by this treatment, but are not cured. Usually cancerous neoplasms are lighted up and their course accelerated by the administration of estrogen preparations. They should never be prescribed until the absence of malignancy has been determined. There is no definite proof that any of the estrogens cause cancer.

Women who have endometriosis or adenomata of the uterus usually improve in health and often become free from symptoms as the climacteric draws to an end. Excessive bleeding and pain, however, may reappear under estrogen therapy.

Thompson believes that women with fibromata of the uterus should not be given estrogens during the menopause as they may cause profuse hemorrhage. Opposed to this view is Karnaky, who advocates the use of large doses of diethylstilbestrol, 25 to 250 mg., injected directly into the anterior wall of the uterus to stop functional bleeding and hemorrhages due to fibroids. He believes that by raising the estrogenic blood level above the estrogenic bleeding level the hemorrhage is checked.

Certain menopausal patients are overstimulated by estrogenic therapy and all of their symptoms exaggerated by it. These women should be treated by other means. Estrogen preparations may cause addiction. It is not unusual to find patients who seemingly cannot do without these drugs and have taken them for a number of years without professional advice. At times they present themselves to physicians because of profuse bleeding brought on by overdosage or sudden withdrawal of the drug. Usually a diagnostic curettage is necessary to rule out malignant changes in the uterus. Following a gradual withdrawal of the drug, substitute therapy must be instituted. Prolongation of the symptom-complex of the climacteric may be caused by unnecessary and too long continued estrogenic therapy. Periods of gradual withdrawal of the drug should therefore be prescribed. If the symptoms disappear or are not troublesome all estrogens should then be stopped.

During the climacteric women who have menstrual disturbances, such as pre-menstrual spotting, menorrhagias and metrorrhagias, present many difficult problems to the attending physician. Treatment of this group is hazardous unless by examinations pelvic pathology is ruled out. Estrogenic therapy often is unsuccessful and radical procedures are necessary. Transfusions of blood, curettage, intra-uterine radium, deep x-ray therapy and hysterectomy are sometimes required to

manage profuse bleeding of the menopause. Certain medicines, however, may be tried, often successfully, before using operative means. Extract of thyroid is especially useful. Well-tolerated doses may be maintained for long periods of time, but while the patient is using this hormone signs of toxicity must be watched for and basal metabolic rates determined.

Androgens are not foreign to the blood stream of women and they may be of great value in treating menstrual complications of the climacteric. The medical profession has been frightened by reports in the literature of masculinizing effects of the male sex hormone. It is true that large doses of these useful androgens will cause hair to grow on the face, a lowering of the voice, atrophy of the breasts, and even enlargement of the clitoris. About 400 mg. of testosterone propionate given in a period of one month will produce masculinizing effects, but rarely is it necessary to give over 250 mg. of the androgens a month in the treatment of menopausal bleeding. Twenty-five mg. of testosterone, given by the hypodermic method three times a week, will lessen bleeding, and 10 mg. of metandren by mouth two or three times a week is sufficient to reduce the blood loss from adenomata and fibromata complicating the climacteric. The androgens find their greatest use in gynecology when patients have had previous malignancies or functional bleeding treated by x-ray, radium or surgery, and estrogens have been contraindicated. Androgens relieve troublesome menopausal symptoms. Hot flashes frequently are checked by the use of these hormones. All masculinizing signs disappear within a few months after discontinuation of the male sex hormone.

A useful group of drugs for the climacteric are the barbiturates. No other treatment is necessary in some cases and when given with the estrogens the dosage of the female hormone may be greatly reduced. Doses of 1/4 gr. of phenobarbital, given one-half hour before meals, and 1 gr. at bedtime, may give complete relief from symptoms.

Many physicians experience great difficulty in weaning menopausal patients away from the estrogen preparations. Christy, in 1945, recommended vitamin E in menopausal therapy in place of estrogen. Personal experience of over two years' duration has confirmed his claims. Women in the

(Continued on Page 1387)

Problems of the General Practitioner in Rural Areas

By J. S. DeTar, M.D.
Milan, Michigan



THE GREATEST problem in rural medical practice today is that of supplying young doctors of medicine to take the places of the older men who are lost by retirement and death. The MSMS is taking all steps to determine that need and to satisfy it.

The Rural Health Survey is being conducted with this specific end in view, and the doctors have contributed $5,000 to start this searching investigation into rural health needs.

The problem is also being attacked by such actions as general practice internships, explanation of general practice by general practitioners in the medical schools. Some schools, notably the University of Wisconsin, have sent their students out to work with rural general practitioners for three months before graduation.

Most rural general practitioners consider that the greatest need in Michigan today is better hospital, x-ray and laboratory facilities in the rural areas. While the Federal Hospital Construction Act will to some extent fill this need, there are many rural areas where the problem will remain for the local residents to solve. It is a problem not only for the doctor but for the residents, because better x-ray, laboratory and hospital facilities enable the modern doctor, both rural and urban, to render better service to the people. Concerted action by local civic groups is far superior to reliance on beautiful blueprints for Federal subsidies with local control; such Federal help always carries with it the possibility of loss of control by community groups.

One of the greatest needs in rural areas is in the field of postgraduate training. The general practice sections of the hospitals and the general practice sections of the state medical societies, with the newly organized American Academy of General Practice, are all tending to return to the general practitioner his rightful place in the American medical plan.

Presented at the Second Annual Michigan Postgraduate Clinical Institute, Detroit, March 12, 1948.

Some Practical Considerations about Endometriosis

By R. L. Haas, M.D.
Ann Arbor, Michigan

ONE OF THE diseases of great interest and importance to all who treat female patients is endometriosis. It is interesting because of the many, as yet, unsolved problems related to it, and important because of its profound influence upon genital function, from the standpoint of menstrual disability and pregnancy.

Much confusion exists regarding the correct terminology to be used when speaking of this disease. One hears of internal and external endometriosis, endometrioma, adenomyoma, adenomyosis, et cetera. Perhaps it is oversimplification to think of it as simply endometriosis, realizing that it may involve any of several structures and be named accordingly. Thus, we have uterine endometriosis, ovarian endometriosis, et cetera. Furthermore, the different varieties of uterine involvement may be designated as the diffuse or circumscribed types, as the case may be. While such a nomenclature may not satisfy the purists, nevertheless it is practical and useful.

The term endometriosis denotes a condition in which endometrium is found growing outside its normal location. One might therefore call it ectopic endometrium. Except for associated features which may occur, this ectopic endometrium is identical with the true uterine endometrium. It is composed of the same glandular elements in a typical stroma, and, moreover, it undergoes the same cyclic variations as does the normal endometrium. It even shows the same decidual reaction during pregnancy. It is, then, obvious that such ectopic endometrium is very definitely affected by the hormonal activity of the ovaries—a point of considerable importance in its management, as we shall discuss later.

It is not necessary to present here an exhaustive list of all the anatomic locations where endometriosis has been found. Suffice it to say, that with rare exceptions, it is confined to the structures of the lower abdomen, including the genitalia, bladder, bowel, peritoneum, rectovaginal septum, and vagina. It is important that, whatever the organ or tissue involved, endometriosis is characteristically associated with adhesions to adjacent structures, adhesions which are dense and usually require cutting rather than blunt separation. Indeed, the latter is fraught with considerable danger, since the density of these adhesions makes rupture of the adherent viscera a very likely occurrence.

Wherever it occurs, endometriosis is characterized by nodules of varying size, usually small, with a typical purple or dark blue color due to the old blood which makes up the contents. Old burned-out implants are represented by patches of blood pigment in adhesions. In the ovary, active implants may grow to considerable size and form the so-called "chocolate cysts" of that organ. It is important to emphasize that all chocolate cysts of the ovary are not endometriosis cysts. Any cyst into which hemorrhage has occurred will be filled with old blood—notably, corpus luteum cysts. Hence, one needs to exercise judgment in treating chocolate cysts. Not all require removal. Next to the ovary the lesions are most commonly found on the posterior surface of the uterus at the level of the internal os, and on the uterine end of the sacrouterine ligaments. As a result of the adhesions associated with these lesions, the colon is often adherent to the uterus in its lower portion, more or less completely obliterating the posterior cul-de-sac.

Implants are also commonly seen on the posterior surface of the broad ligaments, and less often on its anterior surface and the bladder. The other sites described in the literature are uncommon enough that we need not concern ourselves with them here.

The course of the disease is usually one of progression until the climacteric intervenes with its cessation of ovarian function. However, in some instances, the disease apparently becomes inactive for a considerable period of time without obvious explanation. Since endometriosis requires estrogenic stimulation for its maintenance, it follows that regression of the ectopic tissue occurs following the menopause.

One of the unsolved phases of endometriosis is its etiology. The several theories have occasioned a great deal of discussion in the literature, and the papers of Dougal[2] and Counseller[1] will be of value to those interested in the details of these theories. In brief, the theories may be outlined as follows:

1. Endometriosis results from the activation of mullerian duct remains. This theory, of course,

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falls down in cases involving the groin and umbilicus.

2. Endometriosis results from metaplasia of certain tissues which have a common origin with the endometrium from primitive pluripotential coelomic cells. This theory could explain all endometriosis except the very rare ones such as pulmonary or brachial.

3. Endometriosis results from migration of uterine endometrium, either by continuity, implantation, or mestatasis. The latter may be either lymphatic or hematogenous. This migration theory could well explain all recorded sites of the disease.

Although one occasionally discovers asymptomatic endometriosis during laparotomy for other pathologic conditions, most cases are characterized by pain. This may be expressed as dysmenorrhea, acquired and progressive; as dyspareunia; as rectal pain, chiefly during the menses; or as a more or less constant pelvic discomfort. Other symptoms vary, depending upon the organ involved, and among these are bladder irritation or even hematuria, rectal tenesmus or bleeding, and menstrual disturbances.

Examination in a typical case reveals the presence of tender nodulation in the sacro-uterine ligaments and posterior surface of the uterus, which is often retroverted and adherent. There may be tender adnexal masses. Except in rare cases in which the implants involve the vaginal walls, and are therefore visible, one cannot usually be certain of the diagnosis prior to laparotomy.

One of the frequent concomitants of endometriosis is infertility. Whether it is the cause or result of the disease is not always clear. It is suggested by some that the infertility is due to ovarian dysfunction induced by the endometrial implants in the ovary. It is possible that the tubes may be kinked and thus obstructed by the scar tissue and adhesions surrounding implants on the tube or broad ligament, although in most of these individuals tubal patency tests do not show actual obstruction.[4] On the other hand endometriosis does seem to be more common in women who have delayed childbearing until their late thirties than in multiparas of the same age.[3] This might suggest that pregnancy has an inhibiting effect upon endometriosis. Further evidence along this line is to be found in the fact that when pregnancy and endometriosis coexist, the latter is often silent.

The treatment of symptom-producing endometriosis is based upon two principles. Either the stimulation of the lesions by the ovarian activity must be abolished, or the lesions themselves must be destroyed or removed. The former alternative may be accomplished by the administration of testosterone in amounts sufficient to suppress the pituitary and thus the ovary. This form of treatment is being used with increasing success. Symptoms can often be alleviated and an objective improvement in the lesions can sometimes be noted. Testosterone may therefore be used as a diagnostic aid, and indeed its greatest usefulness probably lies here, since its continued use is not only expensive but also precludes the possibility of pregnancy because ovulation is suppressed.

The ovarian stimulation of the lesions may also be abolished by means of castration x-ray or radium and by oophorectomy. However, this form of treatment is generally reserved—for obvious reasons—for those in whom conservative surgical treatment has failed or has been found impossible. It is extremely valuable for those cases with extensive bowel or bladder lesions, since these almost invariably melt away after castration, thus avoiding the necessity for major bowel or bladder surgery.

The second principle of treatment is the destruction or removal of the individual lesions. At the time of operation it is sometimes found that the lesions cannot be removed without sacrificing the reproductive function or without injury to the bowel or bladder. Such lesions can often be destroyed by high frequency fulguration with good result. Conservatism at the time of operation is carried to the extreme in those patients to whom childbearing is very important, even at the risk of being forced to reoperate or later to castrate the few patients whose symptoms persist or recur. It is now a rather generally accepted policy to interrupt certain nerve pathways, the presacral nerves, as a part of conservative surgery when the disease involves the uterus and immediately adjacent structures. This is done in order to render silent any lesions which may have escaped removal or destruction, or which may recur, and reduces the need for subsequent operation or castration.

From the foregoing it is seen that the fundamental consideration underlying our choice of treatment is the preservation of the reproductive function. It should also be emphasized that operation should not be delayed when there is reasonably good evidence of endometriosis, because it is in the early stages of the disease that conservative surgery offers the most. If one waits too long, all chance

of preserving a functional genital tract may be lost. This is not a plea for operation on every painful woman but rather a reminder that endometriosis is generally a progressive disease, and that early diagnosis and operation may therefore be the most conservative course.

In all fairness it should be mentioned that some authors do not feel that such efforts to conserve the reproductive function are justified by the prospects for pregnancy after conservative operation. Counseller,[1] for example, found that among fifty-five patients who had reproduction-conserving operations, only seven subsequently became pregnant, an incidence of 12.7 per cent. However, in a recent survey of patients with endometriosis treated at the University Hospital, it was found possible to preserve the reproductive function in twenty-nine patients. Twelve of these (41.4 per cent) subsequently became pregnant and delivered full term babies at least once.

The picture is not all quite as bright as the above figures might suggest, since one of these patients, after going through one pregnancy and labor perfectly normally, had a considerable amount of pain during her second pregnancy. In the seventh month, acute intestinal obstruction occurred, requiring termination of her pregnancy by section, with resection later of gangrenous bowel. After a very stormy course and a convalescence of several months, she is finally on the way to recovery.

Such a disastrous course during pregnancy after conservative operation is indeed unusual. In fact, no other patient in our group experienced any symptoms which might be attributed to the endometriosis or the operation.

A few of the patients are of special interest.

Case 1.—A twenty-two-year-old single colored girl was first seen because of low abdominal pain, and examination revealed an exquisitively tender left adnexal cystic mass 6 to 7 centimeters in diameter. Since this was the first time the patient had been examined, a conservative course was decided upon. However, signs of pelvic peritonitis shortly appeared, suggesting either a twist of the cyst, or hemorrhage into it. Laparotomy was therefore carried out, revealing a left ovarian endometrial cyst, with extensive endometriosis implants on all the pelvic structures. In addition, there were massive associated adhesions. The cyst was removed and the implants cauterized. The disease appeared so advanced that removal of all of it, or even of both ovaries would be too risky, and it was the operator's opinion that x-ray castration would be required postoperatively. Shortly thereafter the patient married, and four months after operation she conceived. Her pregnancy and labor were entirely uneventful, and now, four years later, she has no symptoms referable to her former disease.

Case 2.—A twenty-three-year-old white nullipara had been observed elsewhere for some time because of sterility and possible endometriosis. Our initial examination confirmed the latter impression, and in addition there was a 6-centimeter cyst of the left ovary. In view of the findings and the marked dysmenorrhea, laparotomy was performed with removal of the chocolate cyst and cautery of the endometriosis implants. She conceived three months later and was delivered elsewhere, and then three years after operation she was delivered here of twins. Both pregnancies and labors were normal, and between pregnancies her menses were no longer painful.

These cases are perfectly characteristic of the results one may expect.

In summary, it may be said that endometriosis is a disease of women in the child-bearing age characterized by the development of ectopic endometrium, chiefly within the pelvis. The disease is usually productive of pain—dysmenorrhea and dyspareunia—and tends to be progressive in most cases. When the diagnosis is reasonably well established (it usually can't be proved until the time of operation), conservative surgery is usually indicated. The value of conserving the reproductive potentiality is to be emphasized. One can expect that at least 40 per cent of patients so treated will subsequently conceive, and their pregnancy and labor will be normal in almost every case.

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LARGE PANCREATIC CYST

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Detroit Physiological Society

Session of October 21, 1948

Effect of Heat on the Nutritive Value of Lactalbumin

Ruth M. Davis, Paul Rizzo and Arthur H. Smith Department of Physiological Chemistry and Anatomy, Wayne University, College of Medicine, Detroit.

Rations containing all the known essential dietary elements, and differing only in their protein components have been prepared and fed to albino rats. The protein of the diets consisted of lactalbumin, unheated, oven-heated at 120°, 140°, or 200° or autoclaved at 120°, or a mixture of synthetic amino acids, unheated or oven-heated at 140°, or gliadin supplemented with heated and unheated lysine monohydrochloride.

The biological value of lactalbumin decreased progressively as the temperature or the duration of heating was increased. Autoclaving the protein accelerated the production of a decrease in its biological value. Lysine and histidine supplements did not significantly improve the nutritive value of the diets containing heated lactalbumin.

Heating lysine monohydrochloride did not reduce its value as a supplement for gliadin and heating a mixture of the ten essential amino acids did not reduce the biological value of such a mixture.

It appears that the reduction of biological value which results when lactalbumin is heated is due primarily to a decreased digestibility of the protein which results from a change in the peptide and/or grid linkages within the protein molecule.

Alterations in Serum Potassium in Acute Myocardial Infarction

Seymour K. Wilhelm, Department of Internal Medicine, Mount Carmel Mercy Hospital, Detroit, Michigan

Profound biochemical changes have been shown to occur as a consequence of tissue injury. Local tissue injury has been shown by Fox and Baer to cause the involved cells to lose potassium from intracellular fluid and gain sodium and water from extracellular fluid. As a result of this electrolyte shift local tissue edema occurred with a liberation of potassium into the general circulation. It was felt by these investigators that not only did the cells of the injured area respond in such a manner, but that all cells of the body participated in a similar electrolyte shift predisposing the organism for the development of clinical shock. Since myocardial infarction is an example of local tissue trauma, an attempt was made to determine whether a similar electrolyte imbalance would exist in this disease. The serum potassium and sodium was determined in several controls and in ten unselected cases of acute myocardial infarction. Chemical methods were used for these determinations. Values for the controls were found to be within the usual accepted range for normal, serum sodium 310-330 mg./ml., and serum potassium 16-22 mgm./ml. (4.1-5.6 m.eq./liter). Serial electrocardiograms were done in each case and the diagnosis of myocardial infarction was established.

In each case studied an elevation of serum potassium was found in the early stages of infarction. The highest levels recorded were 31.0 mgm./ml. (7.95 m.eq./liter), 33.5 mgm. per cent (8.5 m.eq./liter), and 35.8 mgm. per cent (9.75 m.eq./liter). A decrease in serum sodium was found only in some cases. As the patient improved clinically the K level was found to reach normal. The significance of these findings is yet to be determined. A larger series of cases is in progress.

Rh Anamnestic Reaction and Other Remarks on the Mechanism of Rh Sensitization

Charles L. Schneider, Woman's Hospital, Detroit, Michigan

The anamnestic reaction is a renewed antibody formation, in a previously sensitized individual, without renewed exposure to the specific antigen. Such an anamnestic reaction is known to occur for the Rh antibody during pregnancy. The Rh anamnestic reaction is benign. The Rh factor in the cases thus far encountered was Rh_0. This compares with the pathologic Rh reactions of erythroblastosis fetalis, of which probably 90 per cent are for the factor Rh_0. The Rh_0 anamnestic reaction has developed in a few patients who were delivered in our hospital recently. One of these is presented in some detail to demonstrate its bearing on the mechanism of Rh antibody production.

This mother had been highly sensitized by two

previous pregnancies and four transfusions, three of which had not been typed for the Rh factor. Proof of her sensitization is that her second baby developed erythroblastosis and antibody production. During this pregnancy, her third, her antibody development, ante-partum and post-partum, mimicked that of the cases of most serious prognostic import for the fetus, yet after delivery the baby was found to be normal and Rh negative. The fetus had acquired, passively, a high titer of antibody whose duration was comparable to that of passive immunity of the newborn to infectious disease.

It is suggested that the mechanism of maternal antibody production in such cases may be, to a large extent, the mechanism of the same antibody production in Rh incompatability reactions of erythroblastosis fetalis.

Resolution: E. R. Witwer, M.D.

WHEREAS, Eldwin R. Witwer, M.D., has been a member of The Council of the Michigan State Medical Society representing the 16th District for six years' time; and

WHEREAS, his services have been of such outstanding quality, he having served truly, honestly, justly and without stint or thought of himself, and

WHEREAS, The Council and the Michigan State Medical Society and his colleagues have benefited richly by his wise, fair and cheerful counsel, and

WHEREAS, he has found it necessary to regretfully resign his office on The Council for true, valid and necessary reasons, therefore be it

RESOLVED, That the Michigan State Medical Society through its House of Delegates and The Council herewith tender to Eldwin R. Witwer, M.D., its regrets that circumstances have induced him to do so; and be it further

RESOLVED, That it present him with an illuminated and decorative parchment scroll as a small token of its esteem and appreciation as well as its friendship for the many hours of labor, wisdom and energy he has given so willingly, and be it further

RESOLVED, That the Scroll shall read:

> "This Scroll is presented to Eldwin R. Witwer, M.D., by the Michigan State Medical Society, its House of Delegates and The Council in recognition of his long and faithful service, cheerfully, energetically and wisely performed, with keen and deep appreciation for the efforts and sacrifices he has made to further the ideals, principles and tenets of Medicine, and the Michigan State Medical Society, and to benefit his colleagues and friends.—Presented this 23rd day of September in the year of Our Lord nineteen hundred and forty-eight."

and be it further

RESOLVED, That a copy of this resolution be placed on the pages of the minutes of the Michigan State Medical Society transactions and a copy thereof appear in THE JOURNAL of the Michigan State Medical Society.

Third Annual

MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

Grand Ballroom, Book-Cadillac Hotel, Detroit
March 23-24-25, 1949

Time	Wednesday March 23, 1949	Thursday March 24, 1949	Friday March 25, 1949
A.M. 8:30-9:00	Registration Exhibits Open	Registration Exhibits Open	Registration Exhibits Open
9:00-9:20	Surgery Howard K. Gray Rochester, Minn.	Medicine Chester M. Jones Boston	General Practice Frank W. Konzelmann Atlantic City, N. J.
9:20-9:40	Gynecology Harold C. Mack Detroit	General Practice Carl D. Camp Ann Arbor	Surgery Edward J. O'Brien Detroit
9:40-10:00	Pediatrics Ernest H. Watson Ann Arbor	Physical Medicine Frank H. Krusen Rochester, Minn.	Gynecology Charles S. Stevenson Detroit
10:00-11:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:00-11:20	Medicine Robert C. Moehlig Detroit	Anesthesia Ivan B. Taylor Detroit	Pediatrics Hugh McCulloch St. Louis, Mo.
11:20-11:40	Orthopedics George T. Aitken Grand Rapids	Surgery Lawrence S. Fallis Detroit	Urology William Bromme Detroit
11:40-12:00	Allergy George L. Waldbott Detroit	Medicine Sibley W. Hoobler Ann Arbor	Public Health Albert E. Heustis Lansing
P.M. 12:00-2:00	Luncheon D. W. Gordon Murray Toronto, Canada	Luncheon Medical Economics L. Howard Schriber Cincinnati, Ohio	Luncheon Sykes Lecture Harry S. N. Greene New Haven, Conn.
2:00-2:20	Dermatology Harther L. Keim Detroit	Psychiatry O. R. Yoder Ypsilanti	Clinical Pathological Conference (A Medical Case) Donald H. Kaump Detroit, Moderator Mark R. McQuiggan, Detroit Louis J. Bailey, Detroit
2:20-2:40	Medicine Chauncey C. Maher Chicago	Pediatrics William A. Evans, Jr. Detroit	
2:40-3:00	Otolaryngology James E. Croushore Detroit	Syphilis Udo J. Wile Ann Arbor	Surgery William F. Rienhoff, Jr. Baltimore
3:00-4:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
4:00-4:20	Surgery Charles S. Kennedy Detroit	Ophthalmology Don Marshall Kalamazoo	Medicine Howard F. Root Boston, Mass.
4:20-4:40 4:40-5:00	Clinical X-Ray Conference Ben R. Van Zwalenburg Grand Rapids Moderator Lynn A. Ferguson Grand Rapids Edward F. Ducey Grand Rapids	Clinical Pathological Conference (A Surgical Case) Hazel R. Prentice Kalamazoo, Moderator Myrton S. Chambers, Flint Harry M. Bishop, Saginaw	Obstetrics Willard R. Cooke Galveston, Texas Surgery Thomas E. Jones Cleveland, Ohio
6:30	Dinner Hour	Dinner Hour	
8:00-10:00	Question Box Wm. A. Hyland Grand Rapids Moderator Wyman C. C. Cole Detroit Andre J. Cortopassi Saginaw Howard K. Gray Rochester, Minn. H. Marvin Pollard Ann Arbor Donald M. Schuitema Grand Rapids Eugene W. Secord Detroit Walter A. Stryker Wyandotte	No Program Thursday Evening	No Registration Fee at the Postgraduate Institute
10:30 p.m.- 1:00 a.m.	Dance and entertainment for all registrants and their ladies.		

The Institute will be followed by a one-day
Heart and Rheumatic Fever Day
Book-Cadillac Hotel, Detroit, Saturday, March 26, 1949.

A Christmas Message

This month is dedicated to the hope for peace on earth, good will toward our fellow men.

After two great wars, each of which was to bring world peace, we are now, with the atomic bomb hanging over our heads as the greatest threat to mass annihilation, still apparently no nearer that peace.

In the medical profession, we too have not in the past, nor have we now achieved peace and unity within our ranks. At times, do we not fire unthinking criticism at our colleagues which is destructive to both public esteem for the medical profession and also to mutually co-operative activties on the part of the physicians themselves? A fact we have all noted is the dirty linen of our profession which has been washed and hung on the public line by newspapers and magazines for the laity to view.

The spectre of political medicine has suddenly become more real and is now definitely threatening the medical welfare of our people, our profession, and the American way of life. Just hoping and thinking it won't come to pass is not going to preserve the future of private medicine. Unless we, individually and collectively, make up our minds to and do actually unite within our own ranks, we will continue in the manufacture of an "atomic bomb" of our own which will destroy us as surely as the one used in war.

What are you and I doing as individuals and as groups for our County Medical Society, our State Medical Society, and other medical organizations to promote not only scientific progress but unity of accomplishment in the interest of the medical welfare of our people? It is your and my profession to preserve and work for —not wish for. It can only be done by co-operation and tolerance within our own ranks and by the re-establishment of the conviction that our place on earth is based upon *service to our people.*

May the spirit of Christmas renew for each of us not only an understanding mind, but above all, an understanding heart.

E. F. Sladek, M.D.

President, Michigan State Medical Society

President's Page



Editorial

HEART MONTH is February, 1949. The American Heart Association has dedicated this month for its fund-raising drive, beginning February 7 and ending February 29, with special accent on *February 14—Heart Day.*

All members of the Michigan State Medical Society are urged to join in Heart Month activities, by bringing to their patients information on heart disease—America's greatest killer, as well as aiding in the fund-raising drive. Greater financial support is needed to curb heart disease in the state.

ECONOMIC MEDICINE—REBATES

THE LAWS OF the State of Michigan prohibit rebates in the practice of medicine.* The medical profession has frowned upon this practice for many years, yet a condition has grown up which has resulted in much criticism of the medical profession, in adverse publicity, and in announcements through the public press of the indictment of optical companies and ophthalmologists throughout the country. We have never condoned this practice. We believe the furnishing of glasses or of orthopedic appliances or the supplying of drugs and medicine is part of the professional service which a doctor renders his patient, and if these material aids to the bettering of health and physical condition of our patients are dispensed in that spirit by the doctor, no criticism can be made. If, however, the doctor sends his patient to the drug store with a prescription, to the orthopedic manufacturer with an order for appliance, or to the optical manufacturer with an order for a pair of glasses, the doctor should not accept a rebate from the dispenser of his orders.

A set of resolutions was brought into the House of Delegates of the Michigan State Medical Society at the meeting in Detroit, covering the phase of the practice of medicine as related to the prescribing of glasses. The House of Delegates adopted a resolution to the effect that the prescribing of glasses cannot be separated from the professional service of the doctor:

"It is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination," and "we urge that the opthalmologists keep within their management the supervision of optical problems, and accept the responsibility involved in the merchandising of glasses to their patients." —Action, House of Delegates, Michigan State Medical Society, September, 1948.

The above action emphasizes the fact that the problem of merchandising of glasses is truly a moral one if the ophthalmologist assumes complete responsibility for the well-being and satisfaction of his patient. Better Business Bureau holds it is of greater moral significance that we allow this part of eye care to be turned over to all kinds of commercial shops dispensing glasses. The action of the Council of the Wayne County Medical Society on September 10, as quoted in the October JOURNAL, page 1050, is superceded by the official governing body of the Michigan State Medical Society. The action of our House of Delegates will certainly stand out as another "first" for Michigan, taking a bold stand in solving a controversial question.

BAD PUBLICITY

THE SUNDAY papers of October 3, 1948, announced that an opthalmologist in Michigan had been indicted and taken into the Federal Courts of Detroit for accepting rebates. This news item is adverse to the good repute of the profession. It was necessary to read the complete text of the article before it appeared that this man was not indicted or charged with accepting rebates; he was charged for failing to report this rebate money in making out his income tax statements. The Government was not complaining about the rebate, but merely wanted its cut! The judge is reported to have instructed the prosecution office to determine whether there was any actual wrong in accepting the rebates as charged in this recent publicity.

Another piece of not-so-good publicity was the announcement in the Sunday papers of October 10 that the ophthalmologists in Michigan had cheated the State out of five million dollars of sales tax which they had not paid on glasses. This article stated that since 1943 the ophthalmologists, in-

*JMSMS, p. 466, (May) 1948.

stead of paying the tax on the whole charge for glasses, had paid only on the wholesale charge from the manufacturer and thus had defrauded the State of at least five million dollars in the past five years, and that the State proposes to get this money back. It was not until October 19, nine days later that the explanation was made from Lansing, in an article on a back page of a newspaper, that the method of paying sales tax which the doctors have followed since 1943 was in keeping with an executive order from the Revenue Department of the State setting up the method of paying this tax; that there was no criticism upon the doctors for this period, and no fraud upon the State; however, another method of collecting this tax will be devised.

Many inquiries have been made by doctors who are prescribing spectacles, asking what to do in this matter of State Sales Tax. We have advised them to continue as in the past until a different arrangement is made by the State.

A BOUQUET

IN THE SUIT the Federal Government has against two of the major optical companies and 2,750 ophthalmologists throughout the nation, the press reported, October 25, that charges had been withdrawn against 204, and fifty-four were dead. Two of these named were from Michigan.

The attorney representing one of the ophthalmologists indicted told the Editor that he had received a marked copy of THE JOURNAL of the Michigan State Medical Society, April, 1948, from the attorneys in charge of the defense of one of these national optical companies, with the statement that the editorial in that issue was the best exposition and suggestion they had seen regarding this whole rebate matter. An attempt is being made to settle the affair through consent decrees. The progress is slow.

We believe the stand taken by the House of Delegates of the Michigan State Medical Society at the annual meeting in Detroit in September is the most outstanding pronouncement that has been made by any medical organization. This resolution will be found in the minutes of the House of Delegates.

THE SHERMAN ACT AGAIN

IT IS BECOMING increasingly evident that the powers in Washington intend to absolutely dominate the practice of medicine. The *Detroit Free Press,* on October 19, 1948, carried the following item:

"WASHINGTON—(AP)—The Justice Department announced an antitrust action against the Oregon State Medical Society and others.

"It charges they have conspired to monopolize prepaid medical care in Oregon and near-by areas.

"Attorney General Tom Clark said a civil suit was filed in the United States District Court at Portland.

* * *

"DEFENDANTS were the Medical Society, the Oregon Physicians' Service, eight county medical societies and eight individual doctors.

"CLARK SAID THE SUIT ACCUSES THEM OF CONSPIRING 'TO DEPRIVE THE PUBLIC OF THE OPPORTUNITY TO ACQUIRE PREPAID MEDICAL-CARE INSURANCE' FROM OTHERS THAN THEMSELVES.

"The complaint, Clark said, also alleges that doctors have been prevented from practicing medicine in Oregon 'on terms of their own choosing and some of them have been denied the use of hospital facilities in Oregon.' "

This means that an antitrust suit has been instituted against the Oregon State Medical Society, the Oregon Physicians' Service, eight County Medical Societies and eight physicians in Oregon, alleging that they are in restraint of the development of prepayment medical care service in Oregon and surrounding states.

We have received a tremendous amount of literature from Oregon giving in detail the actions of the Government and the reaction of the Society. We are amazed at the implications. On page —, we are publishing the allegations as stated in the summons filed in the District of Oregon on October 18, 1948, Civil Act, File No. 4255. If this policy is continued, every medical and hospital service plan in the nation *could* be made defendants in an antitrust suit from Washington. The expense and efforts of defense could be the ruination of the voluntary prepaid medical and hospital care plans.

This action of the Government, taken with election results of November 2 and the announcement of President Truman, as he started back for Washington November 4, that he was going back to Washington to carry out, with the assistance of a favorable Congress, the promises of his campaign, including compulsory health insurance, could mean that the doctors will all be working for the Government within two years under a socialized medicine scheme, probably identical with that now in effect in England. It has been reported that the details of the British plan were worked out and proposed by representatives of the Federal Security Administration in Washington who went to England for that purpose.

Are We Too Late?

The British Medical Association, in a referendum vote, decided not to co-operate, but the power and the pressure of Government were so great that 95 per cent of them are now co-operating. Have we missed the boat? We, in America, have an object lesson before us and two strikes at least against us. The Government has started an anti-trust suit. The President has announced determination to establish socialized medicine. The demand from labor for national health service has been insistent. We have attempted to provide a remedy in our Blue Cross and Blue Shield plans. Last July, General Hawley told us we were now probably too late in supplying the needs of the people. The Blue Cross and Blue Shield Commissions have been, for several years, trying to work out a method of national sales for organizations of national distribution.

A joint meeting was held in Los Angeles in March and April, 1948. A working scheme was drafted, not accepted, but referred to a committee with instructions to perfect it and report back in six months. Soon after the Los Angeles meeting, several states in the West held a meeting to oppose the Blue Cross-Blue Shield contemplated action. In June, the American Medical Association called a meeting of representatives of State Medical Societies to oppose what they called a "Proposed Merger of Blue Cross and Blue Shield." In September, the Blue Cross-Blue Shield Study Committee made a report with a proposed working plan to be considered at a meeting at French Lick Springs, Indiana, on October 24 to 28. It was charged that this report was of limited distribution, but every member of the House of Delegates in Michigan received a copy during the September session. Early in October, the Council on Medical Service and the Board of Trustees of the American Medical Association held a meeting in which they demanded that no consideration or study be given this report until the House of Delegates of the American Medical Association approved the formation of an insurance company. They contended that the Blue Cross and Blue Shield were attempting to take over the practice of medicine. The suit in Oregon ties in closely with the attempts to work out methods of extending Blue Cross and Blue Shield protection. The obstructing action of various organizations, including the Council on Medical Service of the American Medical Association, has again delayed a progressive move in the voluntary, non-profit medical and health service programs. At French Lick Springs, there was nothing that could be done, but pass the whole matter on to the House of Delegates of the American Medical Association. It is fitting, however, that the final responsibility rest with the AMA, if as a result of dallying and indecision and inaction, the medical profession loses its independence and becomes merely a pawn of the politicians in Washington.

W. S. JONES, COUNCILOR



W. S. JONES, M.D., of Menominee, Michigan, eye, ear, nose and throat specialist, and a very active member in the affairs of the Menominee County Medical Society, was elected to The Council for the Thirteenth District to replace Dr. W. H. Huron who was not a candidate for re-election.

Dr. Jones was born in Jeffersonville, Georgia, June 8, 1890. He was graduated with the A.B. degree at the University of Georgia, in 1911, and the M.D. degree, University of Chicago, in 1915. He served as intern in the Presbyterian Hospital and Children's Memorial Hospital, Chicago, then conducted a general practice in Arizona from 1916 to 1922. After completing a postgraduate course in nose and throat at the University of Pennsylvania and a course in the eye at Knapp's Memorial Hospital in New York and the University of Vienna, he located in Menominee in 1923. He holds the Certificate of the American Academy of Ophthalmology and Otolaryngology. He was a former president and secretary of the Menominee County Medical Society and is now on the staff of St. Joseph's Hospital, Menominee, Michigan, and Marinette General Hospital, Marinette, Wisconsin. He is married and has three children—one son, who is a doctor of medicine, and two daughters.

Dr. Jones comes to The Council as an experienced worker in Medical Society affairs.

YOU—PROFESSOR!

WHEN A PHYSICIAN has been approved by the State Medical Board and granted his license, he feels that now, at long last, he can begin "living" to make up for his years of low in-

come and long hours while he acquired his education and hospital training. It is a privilege, not only financial, to practice medicine. However, he shortly learns that his new job entails numerous responsibilities which he did not see before he entered practice.

He must take his turn serving the county medical society in office and on committees. He must attend hospital meetings. Certain social service organizations that are closely allied to his work require his advice. The community expects him to co-operate, often by giving free physical examinations, in various health enterprises. All of these services he gives freely. But there is a new obligation arising which many doctors have shunned: the education of the public.

Doctors of medicine, following the ethics of the profession, have felt that speaking or writing for the public is a form of self-advertising. Now the demands for speakers on health practices at parent gatherings, for service clubs, schools, and other groups is so great that there are hardly enough medical men available. When M.D.s are not to be found, these social-welfare audiences will listen to less-informed speakers who may not have our profession's viewpoint concerning public health, preventive medicine, and modern therapy.

Have you been impatient with the writers for popular magazines who have told too dramatically of recent medical discoveries? Has your patient asked why you do not use this anesthesia, that miracle drug, or t'other all-inclusive one-shot preventive? What have you done about the annoyance? Perhaps you have written angrily to the magazine, but that does not recall the printed word. Furthermore, the editors will continue publishing health articles because the public loves 'em and they help to sell their journal.

There is little to do about it except to write those popular articles yourself. There are dozens of self-help magazines on the news stands of which you have never heard perhaps. But they are being read by the thousands. The editors are clamoring for health articles by "authorities." Why leave the medical education of the public to reporters and professional writers who often have prejudices or the tendency to overdramatize?

You may have a vague unrest concerning writing for popular consumption because one sometimes is offered remuneration. Dr. Morris Fishbein has no such compunctions (see *The Saturday Evening Post*). Anyhow, what you earn from medical writing can easily be spent on additional hospital equipment you have wished for, so that worry is over!

We talk considerably about the pitfalls of socialized medicine. We are trying to educate the public to our way of thinking. How about educating the public to our way of doing? Our way of practicing medicine? Modern educational psychology admonishes to begin teaching at that point where an interest already exists. Well, patients are interested in themselves; and in us only as we affect their lives. We can obtain an understanding public by simple, straightforward discussions of our materials and methods of treatment.

From here on, it's up to YOU, Professor!

STANLEY T. LOWE, M.D.

ON THE RUN . . . .

Spinal-cord symptoms appearing in the patient with pernicious anemia constitute a medical emergency.

* * *

Neuroblastoma is the most common neoplasm of the abdominal cavity in early childhood.

* * *

Thyroid compression of the esophagus occurs when the gland is fibrous, hard and invasive or when it is situated substernally.

* * *

While 40 per cent of cases of myeloma have normal serum protein levels, 99 per cent show an elevation of the serum globulin.

Selected by W. S. REVENO, M.D.

THE CLIMATERIC AND ITS MANAGEMENT

(Continued from Page 1376)

menopause are effectively relieved of vasomotor instability. There are no stimulating effects and it does not cause changes in the genital organs or the breast. It is well tolerated and has no bad side effects. It may be that the beneficial effects of vitamin E are purely psychological. Perhaps this is just a placebo. However, when ephynal acetate in 10 mg. doses is given three times daily, many menopausal patients are entirely relieved of their disturbing symptoms.

After a period of months or years, women in the menopause gradually realize that their peculiar and troublesome ailments have disappeared. They feel unusually well. Ambition returns and they take their active places again in the home circle and in society. If free from organic disease, they can look forward to many more years of usefulness and happiness. The gratitude of these women is a source of professional satisfaction to physicians who have patiently and skillfully led them through this trying time.

PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES—1948

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MICHIGAN STATE MEDICAL SOCIETY

Eighty-third Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

(Continued from the November issue)

Third Meeting

Tuesday Morning, September 21, 1948

The meeting convened at ten-twenty o'clock, J. S. DeTar, M.D., The Speaker, presiding.

THE SPEAKER: The meeting will come to order.

Is Dr. O'Meara here? May we have the report of the Committee on Credentials?

J. J. O'MEARA, M.D. (Jackson): Mr. Speaker, I have in my hand the names of the credentials from the members who are delegates to this Society, to the number of 76, which is more than 40 per cent of the necessary requirement for a quorum, 50 per cent of which are not from any individual county.

If it is agreeable, this will be accepted as a roll call.

Is there any unfinished business to come before the House?

Are there any new resolutions? This is the last meeting at which resolutions may be presented.

If not, we will proceed to supplemental reports of the Reference Committees. Many of the Reference Committees were unable to finish their work yesterday, and their reports are to be rendered.

Is there a supplemental report of the Reference Committee on Officers' Reports?

Is there a supplemental report of the Reference Committee on Reports of The Council?

XII—b. ON REPORTS OF THE COUNCIL

C. L. WESTON, M.D. (Shiawassee): There is, Mr. Speaker.

THE SPEAKER: Dr. Weston.

C. L. WESTON, M.D. (Shiawassee): Mr. Speaker and Members of the House: The report of The Council as contained in the Handbook was considered by the Committee last evening and reported back. Our report today deals with the supplemental report of The Council.

Item 1 of the Supplemental Report deals with membership. There is no further comment on that,

Item 2, on Finances. There is no further comment at this time.

3. Public Education Account. No further comment.

4. Information to the public. The Committee approves this statement. The Committee believes that the money spent for public relations is wasted unless each and every doctor does his share toward good public relations in his daily contacts with the public.

5. Professional Relations. The Reference Committee recommends the adoption of this policy.

The Committee believes that the over-crowding of patients in public institutions is a public relations problem and that the Michigan State Medical Society should take an active part in promoting better institutional care. We refer especially to state mental hospitals.

6. Michigan Medical Service. No comment was felt necessary.

7. Michigan Hospital Service. No further comment.

8. Second Michigan Rural Health Conference. This was also disposed of yesterday.

9. Full-time co-ordinator for Rheumatic Fever Centers. The Committee commends the action taken in securing a full-time medical co-ordinator for the Rheumatic Fever Centers.

10. Michigan Heart Association. There is no further comment, above the report of The Council on that.

11. Beaumont Memorial on Mackinac Island. The Committee approves of this project.

12. Proposed Veterans Administration Hospital in Ann Arbor. This subject was taken care of in a resolution which was passed last evening by the House of Delegates.

13. New Home for Michigan State Medical Society. The Committee recommends further study on the question of a permanent home for the Michigan State Medical Society and suggests a lease for the time being, rather than a purchase.

In regard to the Recommendations of The Council on page 54 of your Handbook, if you will please refer to the first recommendation of The Council, the Committee approves this recommendation.

Recommendation No. 2. The Committee approves of this recommendation.

Recommendation No. 3. The Committee approves of Organization Seminars and urges that each and every component society be contacted by State Society officers in an effort to assist the component society in setting up and conducting proper meetings.

Recommendation No. 4, in regard to the dues. There is no comment on this recommendation at this time. There will be a recommendation on the resolution concerning dues at the end of this report.

In the matter of the Statement of Policy by The Council, on page 55 of the Handbook, a Statement of Policy re Immunization, the Committee endorses this Statement of Policy. The Committee recommends further that a stronger emphasis be placed on immunization by the family physician rather than by Public Health employees.

Statement of Policy re Venereal Disease Control. No comment.

Statement of Policy re Making Cancer a Reportable Disease. The Reference Committee approves the Policy of The Council.

Statement of Policy re Rheumatic Fever Control. (Page 56 of Handbook) The Reference Committee agrees with this Statement of Policy and recommends that wherever possible this general policy be extended to similar health campaigns.

Statement of Policy re Community Health Centers. The Committee approves of this Statement of Policy.

Statement of Policy on Rh Testing by State Health Department (page 57). The Committee approves this Statement of Policy.

Mr. Speaker, the Committee recommends the adoption of the Report of The Council as a whole, and I so move.

(R. H. Baker, M.D., Vice Speaker, took the chair.)

THE VICE SPEAKER: You have heard the report of the Reference Committee on Reports of The Council. Is there a second to the motion?

E. G. KRIEG, M.D. (Wayne): I second the motion.

THE VICE SPEAKER: Is there any discussion?

If not, all in favor say "aye"; opposed. Carried.

C. L. WESTON, M.D. (Shiawassee): In regard to Recommendation No. 4 of The Council, we mentioned in our report that a resolution introduced yesterday by Wayne County will take care of that situation.

XII—b. SPECIAL ASSESSMENT ($25.00)

"WHEREAS, The need of additional funds for various purposes in the work of the Michigan State Medical Society is apparent; and

"WHEREAS, This need is not static but varies from year to year; and

"WHEREAS, An increase in dues will be of a more permanent nature while a special assessment must be voted each year according to the specific needs; therefore be it

"RESOLVED, That instead of a raise in the dues of the State Medical Society the special assessment of $25.00 be continued for the current year."

The Reference Committee unanimously recommends adoption of this resolution, and I so move.

THE VICE SPEAKER: You have heard the motion of the Reference Committee. Is it seconded?

R. A. SPRINGER, M.D. (St. Joseph): I second it.

THE VICE SPEAKER: Is there any discussion?

All in favor say "aye"; opposed. The motion is carried.

C. L. WESTON, M.D. (Shiawassee): Mr. Speaker, the Committee recommends the acceptance of the report as a whole, including the final resolution, and I so move.

THE VICE SPEAKER: Is there a second?

M. A. DARLING, M.D. (Wayne): I second the motion.

THE VICE SPEAKER: Any discussion? All in favor say "aye"; opposed, "no." It is carried.

Now we have the Report of the Reference Committee on Standing Committees. Is there anything on that?

E. G. KRIEG, M.D. (Wayne): No report.

THE VICE SPEAKER: Is there any report by the Reference Committee on Special Committees?

G. C. STUCKY, M.D. (Eaton): No report.

THE VICE SPEAKER: The next item is the Report of the Reference Committee on Constitution and By-laws. Dr. Spalding.

XII—g. ON CONSTITUTION AND BY-LAWS

(The revised Constitution and By-laws will be published in the January, 1949 Number of JMSMS—Editor.)

E. D. SPALDING, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: The enormous amount of work Dr. Gruber has done on this Constitution and By-laws revision can only be appreciated by those who have actually tried to recheck the thing with him. I am sure that with the work that Dr. Gruber has done and with the work the committees and various officers have done on this at this time, there are no basic changes. It is merely the question of rewriting it and, as Dr. Gruber so properly stated yesterday, taking the By-laws out of the Constitution and clarifying some of the verbiage at certain confused points. There is no fundamental change in principle.

If you will bear with me as we go along, I am quite sure that this can be accomplished without a great deal of time. In other words, to save reading this entire document of twenty-odd pages, those Constitution and By-laws changes as proposed, which you had handed to you in mimeographed copies yesterday, I will not actually read, but read by title, with a few words of ex-

planation where necessary, and will only read those organizations where an actual change has taken place.

Of course, it is perfectly proper, as each chapter and section comes up—whether the committee has recommended a change or not, anyone from the floor who wishes to make a change has that privilege. Otherwise, if it meets with your consent, without objection, we will pass on without actually reading the unchanged parts.

One more point. There is no essential difference in these few changes that are going to be discussed this morning, between the work of Dr. Gruber and the final form gone over by the Committee. This again is just a question of polishing up certain corners and changing some verbiage. Also your Speaker and I see eye to eye on these things, so I wish you would feel that those people who spent time on this thing have no serious conflict in their ideas. I think that will give you a little assurance as to the acceptance of some of this, without unnecessary debate.

Thirdly, I wish to make one important parliamentary point. It is very essential, when you are not revising a part of the Constitution but when you are rewriting all of the Constitution and By-laws, that you do not find yourselves in the middle of the procedure without a Constitution. Until the last vote is taken, you are operating under the Constitution and By-laws as published in the back of this green book, your old and present Constitution. The parliamentary maneuver that we are about to cross is that I will move the acceptance of the proposed revision to the Constitution as presented to you in your vote, by Dr. Gruber, and the By-laws as presented to you yesterday in mimeographed form. I will move the adoption of these two documents, with the additional changes to be listed this morning. We will then vote any further changes, as we go over them this morning, as amendments to that resolution. The amendments will be passed, changed, or voted down, as you wish, as amendments to the fundamental motion. After the thing is amended to suit you, then we will pass the motion for the adoption of the Constitution and By-laws as a whole, and the thing immediately goes into effect.

Do I make this point clear? I don't want any of you to think that something is being put across.

It is quite acceptable. In fact, Dr. Gruber and Dr. DeTar and Dr. Baker and I discussed this thing in detail, and I assure you that it is kosher.

Without more preamble, if you will consult the mimeographed sheets that were handed to you yesterday, there was one resolution and one petition which were referred to the Committee on Change of By-laws, which have definite bearing in this Constitutional revision. As to the resolution, when we come to that portion of the By-laws to which it applies, I will give you the opinion of the Committee on this resolution, and we will pause a moment, and you can vote the resolution in or out, as presented on the floor, and then we will go on, incorporating your decision in the revision of the By-laws.

The other was a petition from Wayne County for additional Councilor representation. In view of the fact that the By-laws specifically provide for such, in case you wish it, now or at any other time, no constitutional or By-laws revision is necessary to accomplish this, and in order not to confuse the issue, I will not bring this petition up until we settle the Constitution and By-laws revisions as a whole, and then we will do as you like about the petition, which I will bring up afterwards.

Now on the mimeographed sheet, first taking up the Constitution and then the By-laws, Mr. Speaker, I move that the proposed revision to the Constitution, as presented a year ago by Dr. Gruber, and the proposed revision to the By-laws as presented yesterday, be adopted, with the recommendations and changes hereinafter to be listed.

(J. S. DeTar, M.D., The Speaker, took the chair.)

The Speaker: You have heard the motion. Is there a second?

W. S. Reveno, M.D. (Wayne): I second the motion.

The Speaker: The motion has been made and seconded. Now is there any discussion?

E. D. Spalding, M.D. (Wayne): The discussion of this, of course, consists of the changes we are about to list.

Taking up the Constitution first, there are only four changes, and only one of them is of any importance.

In Section 1 of Article I, "The name of *the* organization" should be "The name of *this* organization."

I move the adoption of this change.

The Speaker: The motion is that in Section 1 of Article I, of the new Constitution—you will not find this in your Handbooks but this is in the mimeographed copy handed to you yesterday—the word "the" be changed to "this organization."

Is this amendment supported?

R. A. Springer, M.D. (St. Joseph): I support it.

The Speaker: Is there any discussion?

If not, all in favor of passing this proposed amendment say "aye"; opposed. The motion is passed.

E. D. Spalding, M.D. (Wayne): Secondly, still in the Constitution, Article X, entitled "Council," the mimeographed copy states: "The Council shall be the Executive Body of The Society."

It is important at this point to put in a clear definition of just what The Council consists, and following that introductory sentence, this insert is to be placed in Article X, Section 1, after the introductory sentence, and it shall then read:

"The Council shall be the Executive Body of The Society. It shall consist of one councilor from each Councilor District, the president, president-elect, immediate past president, speaker of the House of Delegates, with the secretary and the treasurer, the last two being elected by the foregoing."

Then go on as the mimeographed copy shows.

I move the adoption of this change.

The Speaker: You have heard the motion. Is there a second?

S. L. Loupee, M.D. (Cass): I second it.

The Speaker: Is there any discussion on the addition of these words in Article X after the first sentence?

If not, all in favor say "aye;" opposed, "no." The motion is passed.

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I should like to propose a change in Article III, Section 3. Where it says "and thus to better equip," for proper verbiage it should be "thus better to equip."

I move that be changed.

The Speaker: Dr. Gruber proposes a change on page 1 of the Constitution, Article III, Section 3, to change the wording to read "thus better to equip." Is that right?

Is there a second to that motion?

R. L. Wade, M.D. [Branch]: I second it.

The Speaker: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." It is carried.

E. D. Spalding, M.D. (Wayne): For the information of Dr. Reveno, who is serving as my prompter, in case I slip, there is a minor change in Section 2 of Article X about the immediate past presidents, that we are not bringing up.

This closes the necessary changes in the proposed new Constitution, and we will pass on to the By-laws.

S. L. Loupee, M.D. (Cass): Before we close the discussion of the Constitution, I read Section 1 of Article III and it sems to me that it should be changed a very little bit, the verbiage. It reads now:

"Purposes. To bring into one organization the Doctors of Medicine of This State of Michigan, and through it and other State Societies to form and maintain The American Medical Association."

I wrote in here "and through it and similar Societies of other states to form and maintain The American Medical Association." It makes it a little clearer.

The Speaker: Dr. Loupee, would you be willing to propose in the form of an amendment. that that wording be changed?

S. L. Loupee, M.D. (Cass): I know this is a very precious subject, and that these men have worked hard on it and done a wonderful job. I don't like to offer any change whatsoever which might interfere with their ideas and their construction. If they agree to that change, it seems to me it would help.

The Speaker: Dr. Loupee, we have held many meetings of this Committee and at every meeting we have many changes. So I am sure they are not sensitive. If you would like to propose the amendment, I will put it to a vote.

S. L. Loupee, M.D. (Cass): I propose that in line 2 of Section 1, the words "and similar Societies of other states" be inserted.

The Speaker: Then that would read: and through it and other similar Societies of other states."

S. L. Loupee, M.D. (Cass): That is right.

T. K. Gruber, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

I might say, gentlemen, that this Committee has been far from perfect, as Dr. Gruber will admit, and if anyone sees any suggestion for a change that we can put in the Constitution that we may have missed, please bring it up while we are voting.

Dr. Spalding.

E. D. Spalding, M.D. (Wayne): That closes the amendments to the proposed change in the Constitution, unless there is further comment from the floor.

We will now pass on to the By-laws. As you all know, a revision of the Constitution requires a two-thirds vote, but a revision of the amendments to the Constitution, while they are still in the form of amendments, only requires a majority vote. The By-laws will only require a majority vote.

In Chapter 1 of the By-laws, Section 2, a small change in line 3. It reads:

"The House of Delegates is empowered to revoke the charter of any Component County Society whenever it finds that such Society has materially breached any of the provisions of the Constitution *and*"—it should be changed—"*or* By-laws of This State Society"—not "Constitution *and* By-Laws."

This is a minor change. If there is no objection, shall we pass on?

The Speaker: Is there any objection expressed?

If not, we will accept it.

E. D. Spalding, M.D. (Wayne): These very minor changes, unless you wish to object, I think can be handled without actual vote.

Coming to Chapter 5, Section 5, Member Emeritus, it now reads:

"Member Emeritus—Any Doctor of Medicine who has been in the practice of medicine for fifty years, and who has maintained a membership in good standing for twenty-five consecutive years, may, upon his application and recommendation of his Component County Society, be elected a Member Emeritus—"

The proposed changes are two and very small. It has been thought that many people do not wish to come forward and apply for this. In other words, if the State Society recommended this thing, that was sufficient. On the other hand, there are other men who, although their County Society would gladly recommend such a thing, would prefer to remain as active members. That point is also to be considered.

The Committee thought that that could be gotten around by changing this to read as follows: "who has maintained a membership in good standing for twenty-five consecutive years, may,"— leave out the words "upon his application and"—"*upon* recommendation of his Component County Society, *with his consent* be elected a Member Emeritus."

I propose these two changes, the deletion of "upon his application and" and the insertion of "with his consent" as I have read it.

I so move.

The Speaker: You have heard this motion concerning the provisions for the election of Members Emeritus. Is there a second to that motion?

C. S. Clarke, M.D. (Jackson): I second the motion.

The Speaker: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." It is passed.

E. D. Spalding, M.D. (Wayne): We now come to Section 10, an added section. The last section in Chapter 5 in the mimeographed copy is Section 9.

The new Section 10 of Chapter 5 will read as follows:

"Any change in membership status shall be effected by resolution presented in triplicate before the annual meeting of the House of Delegates after previous certification by the county and state secretaries."

This is to relieve Dr. Foster of the constant need of repeating his requests that these things be put in proper order, and it is so stated here, specifically so, so that everybody will know exactly what is required. It is no essential change, but merely eliminating the procedure.

I so move.

The Speaker: You have heard the motion. Is that seconded?

W. S. Reveno, M.D. (Wayne): I second it.

The Chairman: Is there any discussion?

E. D. Spalding, M.D. (Wayne): I might ask if that is satisfactory to Dr. Foster.

The Speaker: Is there any suggestion by Dr. Foster?

Secretary Foster: Does the wording say "the county and state secretaries"? Shouldn't it read "secretaries of the county society and state society"? It could almost sound like the Secretary of State.

The Speaker: Would that be agreeable in the last line, to change that to "the secretaries of the county and state societies"?

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I move the acceptance of the amendment.

The Speaker: Dr. Gruber moves an amendment to the proposed amendment, to the effect that the wording be changed to read, "after previous certification by the secretaries of the county and state societies." Is there any discussion on Dr. Gruber's amendment? Is it supported?

E. G. Krieg, M.D. (Wayne): I support it.

The Speaker: Is there any discussion on the proposed amendment to this amendment? If not, all in favor say "aye"; opposed, "no." The amendment to the amendment is passed.

Is there any discussion on the amendment proposed by Dr. Spalding, to the effect that this additional section be added to Chapter 5? Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): Chapter 6 of the By-laws has to do with the discipline of membership, in a large number of sections. There is no change suggested until we come to Section 9. The verbiage here, as you have it on the mimeographed form, is a little confusing.

Section 10 and Section 12 should follow one another consecutively, and Section 11 should be placed at the end, allowing Sections 10 and 12 to follow each other directly. So the first proposed change is to renumber Section 12 as Section 11, and put Section 11 at the foot and label it Section 12. That is merely clerical and needs no vote unless somebody objects.

Now the confusion arising between Section 10 and what is now the section below it, Section 11, labeled Section 12 on your copy. If the first sentence in Section 12, as labeled in your copy, is deleted and put into Section 10, it will be clearer. I will read it as it would be changed, if it has your approval.

Section 10 will now read—deleting the first six words—"No order shall become effective until"—and starting the sentence at that point:

> "The affected member shall have an opportunity to avail himself of his rights of *further* appeal according to the following procedure: Appeal to The Council of this State Medical Society; appeal to the House of Delegates of this State Medical Society; and final appeal to the Judicial Council of the American Medical Association. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by a component County Society Council may appeal to his Component County Society."

A word of explanation. The purpose of this is as follows. In those small county societies where the society acts for itself, this does not come up, but in Wayne, where we have over 2,000 members, such an organization is totally unwieldy and such action is taken by the council representing the society. The council of Wayne County has 20-odd members in itself. There is one other county society and possibly two where they have a council. This provision is to make it perfectly clear in the records as to what is the procedure, whether there is a council or whether there is not. We feel that the first action on the recommendations of the Ethics Committee in the smaller societies could be by the society itself, but in the big societies with the council the recommendations of the Ethics Committee go to the council and the council takes such disciplinary action as it sees fit.

However, we cannot deprive a member of the right to appeal to the society as a whole if he wishes such adverse publicity.

Therefore, this is merely to put definitely into the record what such rights are.

May I read this once again as corrected?

> "Section 10. The affected member shall have an opportunity to avail himself of his rights of further appeal according to the following procedure: Appeal to The Council of this State Medical Society; appeal to the House of Delegates of this State Medical Society; and final appeal to the Judicial Council of the American Medical Association. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by a component County Society Council may appeal to his Component County Society."

In view of the fact that this and the next section really go together, may I ask that they be acted upon together?

Passing on from Section 10, as I have outlined it, to the next contiguous section, labeled No. 12 on your list but now labeled No. 11, you will delete the first two lines and reverse the order of the following sentence, so that the three words at the end of the third line shall come first in the sentence, and the section will now read—We have taken care of the first sentence, "A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by his Component County Society, may appeal therefrom to The Council of The Michigan State Medical Society," in the section I have just outlined and deleted it from this section. Now this Section 11 will read:

> "Notice of appeal to The Council of The Michigan State Medical Society shall be in writing and set forth"—and go on just as it is listed.

It is merely taking one sentence out of the second section and incorporating it in the first for clarity. This is a little confused. Do you wish it read again? Shall I read the two together?

Delegates: No.

E. D. Spalding, M.D. (Wayne): I think I will. It is an important point. It will now read.

(Dr. Spalding reread the amendment.)

Now one more statement. Going back one to Section 9, the one on the Ethics Committee, there is an insert, and I will read: "The Ethics Committee may reprimand or counsel a member; however, discipline must be meted out by The Society as a Whole *or its Council.*" That is an insert. "A two-thirds vote of the members present of the Component County Society *or its Council,* due notice having been given, is necessary for expulsion or suspension of a member."

Then you go on as I have outlined.

I moved the adoption of these changes, if they are not too complicated.

The Speaker: The motion is for the adoption of the changes in Sections 9, 10, 11 and 12 of Chapter 6 as read. Is there a support?

W. S. Reveno, M.D. (Wayne): I support it.

The Speaker: Is there any further discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): Carrying on now, Chapter 7, under the heading of General Sessions.

Chapter 7. The General Sessions is unchanged.

Chapter 8, House of Delegates, at the top of the page. Section 1 has been clarified as follows: The last line has been taken up and put ahead of the second sentence. The thing that is being transposed and put up ahead is:

"Reports having been properly filed with The Secretary of This State Society"—then go on with the second sentence:

> "Reports having been properly filed with the Secretary of this Society, each Component County Society shall be entitled to send to The House of Delegates each year one delegate for each fifty members and one delegate for each additional major fraction thereof. Any Component County Society"—

and now delete the unnecessary words "which holds a charter from This State Society" and put in "having" instead of "has" so it reads:

> "Any Component County Society having less than fifty members shall be entitled to send one delegate."

I will now read it without interruption.

Section 1 of Chapter VIII, Composition. "The House of Delegates shall be composed of Members elected by The Component County Societies. Reports having been properly filed with the Secretary of this Society, each Component County Society shall be entitled to send to The House of Delegates each year one delegate for each fifty members and one delegate for each additional major fraction thereof. Any Component County Society having less than fifty members shall be entitled to send one delegate."

I move the adoption of Section 1 as amended.

The Speaker: Will you read the last sentence again?

E. D. Spalding, M.D. (Wayne): The last sentence will read: "Any Component County Society having less than fifty members shall be entitled to send one delegate."

The Speaker: You have heard the proposed amendment. Is there any support?

J. J. Lightbody, M.D. (Wayne): I support it.

The Speaker: Is there any discussion?

J. J. Lightbody, M.D. (Wayne): I wonder if that means active members? Does that take in all classifications of members?

The Speaker: The question is whether that takes in all classifications of members. Can you clarify that, Dr. Spalding?

E. D. Spalding, M.D. (Wayne): I assume that is so. The verbiage is the old Constitution. Can the Secretary correct us on that?

The Speaker: Dr. Foster says that the old Constitution has referred to all classifications having a vote. I wonder whether that should be clarified in the new Constitution, whether the question will come up again.

E. D. Spalding, M.D. (Wayne): How did you determine, Dr. Foster, whether a society was entitled to one, two or more delegates?

The Secretary: The allocation of delegates to the House of Delegates at the present time is based wholly on all of the members, of any classification whatsoever, voting or otherwise. In other words, if the county society has 76 members, and in that group there are all categories—retired, emeritus and so on—they are all calculated in the determination of how many delegates they have at the present time.

E. D. Spalding, M.D. (Wayne): Mr. Chairman, that has now been the procedure for all time. I don't think it should be changed.

The Speaker: Is it understood by the delegate who asked the question that if the wording remains the same all members will be included, including life members, honorary members, and all

members? Is that the meaning, Dr. Gruber, that your Committee intended to put into this wording?

T. K. GRUBER, M.D. (Wayne): Yes.

THE SPEAKER: That has been the custom in the past. Is there any question or any objection to the present wording, which obviously would include all members of the Society at all times?

There is no objection. Is there any discussion on the motion to adopt this amendment?

If not, all in favor say "aye"; opposed, "no." The motion passed.

E. D. SPALDING, M.D. (Wayne): We now come to a point on which there may be a great diversity of opinion, and it is a very simple and direct point. The verbiage is not at all complicated. Do you want one or two regular meetings of this House of Delegates a year? The Committee has no opinion on this. If you want to leave the Constitution as it is, you have one regular annual session of the House of Delegates at the time of the annual meeting of the Society.

THE SPEAKER: Pardon me, Dr. Spalding, but before you get involved in the next subject, I would like to bring up one point which Dr. Foster has been discussing since we made our last vote. According to our decision, all members who are on the roster of any County Medical Society will be included in computing the number of delegates privileged to come to the House of Delegates. That will include active members and life members and membrs emeritus and honorary members, and also associate members, if we make no distinciton.

There are some societies, particularly Wayne County and Washtenaw County, which may have 15 or 20 or 30 or 40 or 100 internes as associate members. I raise the question to the House, before we go on, whether we care to eliminate the associate members from the category of members in the Society, which determines the number of delegates we may have. I bring the question before the House.

T. K. GRUBER, M.D. (Wayne): We do not include any but voting members in our report to the Secretary, in computing the number of members that we have in the Wayne County Medical Society. Associate members and nonvoting members are not included.

THE SPEAKER: Dr. Gruber says that Wayne County does not include any but voting members. According to the wording we agreed on a few moments ago, any members may be included.

R. L. NOVY, M.D. (Wayne): At the suggestion of Dr. Luce, I call your attention to the fact that if you exclude a lot of those your representation in AMA will be cut down proportionately.

THE SPEAKER: Dr. Novy, you mean if we exclude—

R. L. NOVY, M.D. (Wayne): Those various categories you have mentioned who have been closely allied and have an interest in your medical societies may be excluded in your representation and your representation in AMA will be proportionately cut.

THE SPEAKER: If we exclude associate members, in other words, from the list of members it will determine the number of delegates we may have in this House of Delegates. Is that what you mean?

R. L. NOVY, M.D. (Wayne): Not in this House of Delegates, but in the AMA delegation quota.

THE SPEAKER: You have heard the point.

Dr. Gruber!

T. K. GRUBER, M.D. (Wayne): Dr. Foster, do you include associate members in your report for our quota in the AMA?

THE SPEAKER: Dr. Foster!

SECRETARY FOSTER: As a matter of fact, there are only about two societies in the state where we do not include them. The point I was making to Dr. Spalding is that the people who are included in this calculation are those classifications of membership which include men who had at some time or other enjoyed active membership and who, through some honorary contribution by this House have been put in these special categories. Associate members in some societies have never been members. They have been interns and residents and folks who have not been members. The calculation in the office for our allocation of delegations is based on those categories containing men who have at some time been active members, like Emeritus, Retired, Honorary, and so on, where they have been active members but through the various provisions of the Constitution have been given these honors, but not those who have never been members or who are laymen or who are just put in like the associate membership.

Of the 55 county societies there are only one or two who have any associate membership, and they are not figured in our calculation—just the categories that were predicated originally on active membership.

E. D. SPALDING, M.D. (Wayne): Lest you feel that Wayne County is taking an unfair advantage, the number of associate members in Wayne is not great if you take into consideration the fact that we have over 2,000 members. It is a drop in the bucket.

I think it complicates things a little bit to make this distinction. I grant Dr. Foster's point, that it should be limited to those who have at some time had an active part, but if I may be pardoned, I should like to refer to a time-honored story about two young ladies to whom the comment was made, "You girls aren't ladies of the evening," and they said, "Why, nosuh, we ain't, but we hopes to be." These general interns hope to be members, and I think it would be all right to consider them as such.

I assure you that Wayne will get no advantage with 2,000 members as a whole. It will be a drop in the bucket.

THE SPEAKER: Before we leave the subject, I would like to ask if the House is satisfied with the present wording, as adopted in our last motion—if there is no objection, if there is no limit.

R. J. ARMSTRONG, M.D. (Kalamazoo): I would like to know if there is anything in this proposed group of By-laws that specifies this matter. It seems uncertain whom you are going to include in counting.

THE SPEAKER: I wonder if Dr. Spalding will read the final wording, which indicates which members will be used to determine the number of delegates.

E. D. SPALDING, M.D. (Wayne): The By-laws do not specify, to the best of my knowledge, anything on that, and simply refer to members. I think if you will leave it unqualified, you will benefit yourself in the AMA and you will not prejudice yourselves here.

THE SPEAKER: Is there any further discussion?

If the House is satisfied, we will proceed to the next paragraph. Dr. Spalding.

E. D. SPALDING, M.D. (Wayne): As you recall, Dr. Gruber brought this point up before the previous objection, and the thing we have been discussing for the moment, which we will now resume, is: Do you want two or one session a year? The Committee is quiet on this thing.

In Section 4 it says: "The House of Delegates shall meet annually at the time and place of the meeting of This State Society as a Whole, as when it meets in General Session, and may hold such number of meetings as The House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meetings."

If you wish, you can put in the additional sentence: "It shall also hold a session between annual sessions at a time and place to be fixed by The Council of the Society."

The reason you are delegating the fixing of the time of your meeting to The Council is that you cannot meet if you cannot find a place to meet, and if you think that this House of Delegates can find a place to meet at the drop of a hat, try it. The Council will have a hard enough time, as a small body, to determine where physical facilities are available and what the time shall be for such special meeting within two or three weeks. That is why it is allocated to The Council, if you so wish.

On the other hand, if you wish to continue with one meeting a year, with the understanding that a special meeting can always be called, this does not need to be placed in.

For the sake of making it specific, the Committee suggests that this additional sentence be put in at the end of Section 4:

"It shall also hold a session between annual sessions at a time and place to be fixed by The Council of the Society."

If it is your pleasure to have but one meeting, one regular meeting a year, that will simply not be included.

I move this insertion as an amendment.

THE SPEAKER: You have heard the motion. Is it supported?

C. L. WESTON, M.D. (Shiawassee): I support it.

THE SPEAKER: Now I wonder if we all realize the full import of this proposed amendment. Those of you who have your copies, this is Chapter 8, Section 4. May I read it again? It reads:

"It"— that is the House of Delegates—"shall also hold a session between annual sessions at a time and place to be fixed by The Council of the Society."

Is there any discussion on this amendment?

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, I think I might be a little more explicit, if instead of voting this amendment for the moment, we simply voted the question: Do you want two regular meetings a year? Then we can discuss the verbiage later. I want this point perfectly clear.

Therefore, if I may, the motion that I will put to the Chair will be that we continue with one meeting a year. Vote it down, if you want to. Then we will go on with the other.

THE SPEAKER: The Chair will recognize this motion, that the House of Delegates continue to have one regular meeting per year.

Is there a second to that?

D. C. BLOEMENDAAL, M.D. (Ottawa): I second it.

THE SPEAKER: Is there any discussion on whether the House of Delegates shall have one meeting or two?

L. W. GERSTNER, M.D. (Kalamazoo): It is largely personal, but it seems to me that the cost of such a meeting must be quite high, and certainly the aggregate cost of coming to such a meeting for an entire delegation also must be exceptionally high. I believe that from the economical angle, a second meeting is not practical.

I also feel that if a single meeting will accomplish the same result in the great majority of cases, we might better have one annual meeting, and even though it is a job to find a place for a special meeting, we may rarely need such meeting.

I would like to see but one meeting a year.

THE SPEAKER: Is there any other discussion on the motion? The motion is that we shall have one regular meeting a year.

R. H. DENHAM, M.D. (Kent): May we not insert the privilege of having a second meeting if it is deemed advisable by The Council?

THE SPEAKER: That question I should like to refer to Dr. Spalding. I should like to ask Dr. Spalding whether it would appear later in the Constitution that The Council may call a special meeting of the House of Delegates at any time.

E. D. SPALDING, M.D. (Wayne): It is perfectly possible to call a special meeting at any time it seems advisable or there is urgent need.

THE SPEAKER: That is in The Council.

E. D. SPALDING, M.D. (Wayne): Whether it is or it is not, the question is: Do you want two regular meetings or one regular meeting?

THE SPEAKER: The motion is that we shall continue to have one regular meeting per year. Is there any further discussion?

S. L. LOUPEE, M.D. (Cass): I think now is the time to express our opinions.

THE SPEAKER: Yes.

S. L. LOUPEE, M.D. (Cass): I am in favor of one meeting.

THE SPEAKER: Is there any further discussion?

If not, all in favor of the motion that we continue to have one

regular meeting of the House of Delegates per year say "aye"; opposed, "no." The motion is passed.

Dr. Spalding, will you read your—

E. D. Spalding, M.D. (Wayne): That obviates the necessity of making this change. It was simply introduced to give you a vehicle to express the contrary idea if that was your view. So there will be no change there.

That won't ball up the works, will it, Dr. Reveno? Just drop out that one sentence.

Now Section 6, which is a little different type of thing. We are still under the House of Delegates, Section 6, It became complicated as to whether a delegate elected at one meeting but failing to sit, and his alternate was put in his place, would be the delegate if you had a second meeting. If you are not having any second meeting, no change need be made in Section 6. So the suggested change there to take care of that will simply also be eliminated.

As the thing now reads, and you have a special meeting—

"A Delegate once seated shall remain a Delegate throughout the entire session and for one year thereafter until the next Session of This House of Delegates."

In other words, if an alternate once takes the place of a regular delegate, if there is a special meeting that alternate sits until the second meeting. That is the way your Constitution now is, and unless you are having another regular meeting, I think it would be best to leave it just as it is.

So the Committee recommends no change, unless somebody wishes to make some change in Section 6 at this time. Otherwise it will stand as it is.

Still under Chapter 8, House of Delegates, going on to Section 10 under Alternate Delegates and then a variety of subsections and so on, you come down to page 8, to subsection (j).

The Committee feels that as it is given in the mimeographed sheet there are a large number—14 to be exact—of committees specified, and then other committees if you wish. These are regular committees. This is a little burdensome, and the suggested change is that subsection (j) read not "It *shall* have the following reference committees," but "It *may* have the following reference committees, together with Tellers and Sergeant at Arms," and so on.

I move the change of the word "shall" to "may." "It *may* have the following reference committees."

The Speaker: You have heard the motion. Is there a support?

W. S. Reveno, M.D. (Wayne): I support it.

The Speaker: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." Motion carried.

E. D. Spalding, M.D. (Wayne): Passing on to Chapter 9, Council third line, it specifies here: "It shall hold an Annual Meeting in January of each year—" That is inadvisable. There are times when that should not be, and if the words "in January of each year" are deleted, it will read:

"The Council is the Executive Body of this State Society. It shall determine its own time and place of meeting. It shall hold an Annual Meeting at which time it shall elect to serve one year its Chairman," and so on.

That merely eliminates the necessity of placing that meeting in January, which might not be convenient.

I move the deletion of the five words—in January of each year.

The Speaker: You have heard the motion. Is it seconded?

R. W. Teed, M.D. (Washtenaw): I second it.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): The same applies to Chapter 9, Section 7, in which—

"The Council shall elect an Editor of The Journal of the Michigan State Medical Society, and a Treasurer at its annual meeting *in January of each year.*"

If the first goes out, the second goes out automatically and it needs no vote.

We are almost through gentlemen.

Under Chapter 10, Standing Committees, Section 3—"Committee on Preventive Medicine shall consist of its Chairman, The State Health Commissioner, and Chairmen of the following Committees—"

and there is a long list given. There is inserted here a committee that does not appear before, namely the Committee on Diabetes. It has not seemed to the Committee necessary that this be inserted. The section goes on to state "Such other Committees as may, from time to time, be appointed to study and develop programs dealing with specific diseases." At the present time it was not felt necessary to complicate the list by adding the Committee on Diabetes.

This is not in your present Constitution, so one amendment is to delete the name of the Committee on Diabetes, as printed in your mimeographed sheet.

The Committee on Heart and Degenerative Diseases, which appears above that, has been with us for a considerable time. On the other hand, you now have a very active Rheumatic Fever Control Committee, which takes care of heart disease in the other group. Now the question comes up, Why specify heart and degenerative diseases? The Committee moves that that be changed to the Committee on Geriatrics, which makes a more general occupation.

Therefore, the proposed change is the change in the name of the Committee on Heart and Degenerative Diseases to Committee on Geriatrics, and the elimination of the Committee on Diabetes. Any of these can be inserted, if necessary.

I so move.

The Speaker: You have heard the motion. Is there a second?

E. G. Krieg, M.D. (Wayne): I second it.

The Speaker: Is there any discussion on the motion to eliminate the Committee on Heart and Degenerative Diseases and the Committee on Geriatrics and eliminate the Committee on Diabetes?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): We now come to Chapter 11, Officers. There is one small change in Section 9. This will probably appear to you like counting the angels dancing on a pin, but it is an important parliamentary point. It is right in the constitution, and the man who put this in originally didn't know his constitution at all. When you elect a man to preside over your House, you do not deprive him of his franchise to vote. That is absolutely fundamental.

Now the fact that the presiding officer usually does not vote is simply because the vote usually isn't necessary, but if the vote is by ballot, the presiding officer in any meeting always votes at the time the ballots are collected, and not later, so in case there was a tie, his vote would have been registered. That is always so.

In Section 9, speaking of the Speaker of the House of Delegates, it says he shall preside at sessions, do this, that and the other thing, and it goes on and says: "He shall have a right to vote only when his vote shall be the deciding vote." That is totally unnecessary. It is confusing. As some of you may not know, not only may a presiding officer vote to break a tie, but he can vote to make a tie, and therefore defeat a motion. There is only one motion in the book which can be determined by a tie vote, and that is a motion to support a parliamentary decision of the Chair. All other motions require a majority vote, with one exception. We won't go into that.

Therefore, in view of the fact that your Speaker, according to parliamentary procedures, has the right not only to break but to make a tie and therefore defeat the motion, don't complicate the situation by the insertion of this statement. Parliamentary rules are perfectly specific out of this book. This is merely confusing.

The Committee moves that in Section 9 the sentence be deleted: "He shall have a right to vote only when his vote shall be the deciding vote."

I so move.

The Speaker: Is this motion supported?

T. K. Gruber, M.D. (Wayne): Second the motion.

The Speaker: You have heard the motion. It has been supported. Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): Two more points.

Chapter 12 deals with the referendum. To the best of my knowledge, extending back over some twenty years in this House, we don't have referendums, but it is here in case.

In the first place, Section 1, under Referendum, Chapter 12, deals with this problem. The General Session of your Society has a right, by a two-thirds vote, under your Constitution, to take unto itself a decision which is before the House. The Society can take such a decision away from you by a two-thirds vote and decide it themselves. That Section 1 we are not changing.

Section 2 is the reverse. In case a very important point is up before the House of Delegates, a very moot point, and they do not feel that they have been sufficiently instructed by their representatives as to how they should vote, they can refer it back to a General Session and let the General Session vote.

Now the machinery of accomplishment of this is a little clumsy. Remember, those of you who are upstate, if the emergency should arise and the weather was bad, it might be that you would find yourself represented by Wayne, and that would be a terrible thing.

Therefore, it is the feeling of the Committee that it would be much better in such case of an important matter, that the House of Delegates felt they were unable to go there, that this should not be by any haphazard meeting in the middle of the winter, when it was difficult to get here or there, but this vote should be taken by the constituent county societies, and vote on the question certified, the vote of each county society certified by its secretary and sent to the Secretary of the State Society, in case such a matter was referred to the Society as a whole by the House of Delegates.

If this is your pleasure, it can be accomplished by changing Section 2 to read as follows:

"The House of Delegates, by a majority vote"—

crossing out the words "of its members" which is not necessary—

"may submit any question pertinent to the community and organized medicine to the membership of The Society for its vote"—

Delete the next three lines, which are quite garbled English, and insert the following:

"Such vote to be taken by County Societies and certified by their secretaries to the Secretary of the State Society. Two-thirds of the vote cast shall be required to carry the question."

It probably never will arise, but if so, for heaven's sake have a piece of machinery that is usable.

I recommend the adoption of this change.

T. K. Gruber, M.D. (Wayne): I second the motion.

The Speaker: It has been seconded by Dr. Gruber. Is there any discussion?

S. L. Loupee, M.D. (Cass): As I listen to the able presentation of this matter, I can see yet that you are not quite clear in specifying whether this final vote should be by counties or by the membership of each county society. I presume you mean by the membership of each county society, but it might be that each county was voting as a unit. Which do you mean?

The Speaker: Dr. Spalding.

E. D. Spalding, M.D. (Wayne): It is their verbiage. Wayne has always been accused of voting as a unit. I would suggest that some of you attend our caucuses. If you can get unity in Wayne, you can be President of the United States.

I think the verbiage is plain—"Such vote to be taken by County Societies." Of what do the county societies consist unless it is of their members, and nothing is said as to whether they vote as a bloc or anything else. That is up to them to decide. They can report their vote by societies certified by their secretaries. If you wish to change it, do so.

S. L. Loupee, M.D. (Cass): Mr. Speaker, Dr. Spalding has failed entirely to get my point.

E. D. Spalding, M.D. (Wayne): I am sorry.

S. L. Loupee, M.D. (Cass): I don't expect absolute unity in one society. That wouldn't be democracy. What I propose is that you should be specific as to how this vote is to be recorded, whether it is to be such-and-such a county votes "yes" or "no"—that the vote be by counties or counting the individual votes.

E. D. Spalding, M.D. (Wayne): It is the same problem evidently as when we vote for the President of the United States. We vote by states. I get your point. It is a good one I think.

W. S. Reveno, M.D. (Wayne): I think the section is quite clear. In the first place, this chapter deals with the referendum and, secondly, Section 2 begins with this clarifying statement: "The House of Delegates, by a majority vote, may submit any question pertinent to the community and organized medicine to the membership of The Society for its vote."

That is a vote of the membership of the entire Society and is arrived at by appealing to the various County Societies to poll the vote from the individual members.

The Speaker: Then go on. "Two-thirds of the vote cast shall carry the question." In other words, two-thirds of the vote cast by the members of the State Society. Is that right?

Is there any further discussion? Are there any amendments proposed? If not, the motion on the floor is to adopt the revision of Chapter 12, Section 2, and we will put it to a vote. All in favor say "aye"; opposed, "no." The motion is passed.

E. D. Spalding, M.D. (Wayne): I think when the two sentences of Section 2 are taken in conjunction the point is clear. Thank you for bringing it up. I think it is a good point.

I will pause one moment and call your attention to one of the mixed verbiage things in here. It says "provided further that two-thirds majority of the members." Will somebody on the floor kindly tell me what a two-thirds majority is, a majority being more than half? That is just a comment on the side.

Finally, one of the minor points in Chapter 16, Section 1:

"At The Annual Meeting of each Component County Society or at a designated meeting of which ample notice has been given, each Component County Society shall elect"

and the text says "Delegates or Alternates." It is a typographical error and it should be "Delegates and Alternates." I just call it to your attention. It is not necessary to vote on that unless somebody objects.

Now, Mr. Speaker, we now get to the point where having amended the proposed changes, both to the Constitution and By-laws to your satisfaction, the question now before the House is to vote on the question of the adoption of the Constitution and By-laws.

The Speaker: The motion has been made to adopt the Constitution as presented to this Society a year ago, which was held over for one year, with minor alterations as delineated by the Chairman of the Reference Committee on Constituition and By-laws and also the By-laws as amended today.

Is there any further discussion on this motion?

L. C. Harvie, M.D. (Saginaw): I think we should have a little more clarification as to how the delegates will be tabulated for this House.

As in the Constitution now, that has been read, in order to elect delegates a County Society shall have 50 members for each delegate or a fraction thereof. Some clarification should be made as to active members. As was stated a while ago, the associates could be tabulated. As a member of the special committee, we just certified 30 on associate memberships from Washtenaw. Those members are not active, and that would entitle Washtenaw to an extra delegate. It seems to me some clarification should be made.

The Speaker: Dr. Harvie refers to Chapter 8, Section 1. I think we should ask the Chairman of the Reference Committee to read again the phrase which we adopted tentatively as an amendment. I have it right here.

E. D. Spalding, M.D. (Wayne): Section 1 as amended this afternoon reads:

"Section 1. House of Delegates. Composition. The House of Delegates shall be composed of members elected by the component County Societies. Reports having been properly filed with the Secretary of this Society, each component County Society shall be entitled to send to The House of Delegates each year one delegate for each fifty members"—unqualified—"and one delegate for each additional major fraction thereof. Any component County Society having less than fifty members shall be entitled to send one delegate."

W. W. Babcock, M.D. (Wayne): I would like to point out that some societies have associate members that are laymen and also that some county societies have nonresident members. I agree with Dr. Harvie that the members who come as delegates, for delegates, should be specified. I might suggest that the words "active, life and emeritus"—I believe those are the three groups—be inserted so that there will be no question.

The Speaker: You are making that suggestion. It is possible for any member on the floor to move, in order to get this taken care of, that some action be taken to change the wording in Section 1. Chapter 8.

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I move the reconsideration of that motion to adopt this Section 1.

The Speaker: Dr. Gruber, you are moving reconsideration of the amendment which was passed concerning Chapter 8, Section 1?

T. K. Gruber, M.D. (Wayne): Yes.

The Speaker: Is there a second to that motion?

C. S. Clarke, M.D. (Jackson): I second it.

The Speaker: All in favor of reconsidering Chapter 8, Section 1 say "aye"; opposed, "no." The motion is passed.

The question before the House now is as to the wording or rewording of Chapter 8, Section 1.

W. S. Reveno, M.D. (Wayne): I have one suggestion which may eliminate the questions that have been raised, particularly with regard to the possibility of including nonprofessional members, and the suggestion is simply that we insert the words, between where it says "for each fifty members"—"for each fifty *professional* members." That would include all varieties of membership, with the exception of the associate members that are not in the profession or have not been included and granted a vote in the County Society.

The Speaker: You have heard the suggestion that the word "professional" be inserted before "members."

E. D. Spalding, M.D. (Wayne): What is the profession, may I inquire?

The Speaker: Whose profession?

T. K. Gruber, M.D. (Wayne): I propose to amend this in lines 1, 2, 3, 4—"The House of Delegates each year one delegate for each fifty *voting* members and one delegate for each additional major fraction thereof."

Voice: Support it.

The Speaker: The motion is to amend Chapter 8, Section 1 to the effect that the word "voting" be put between the words "fifty" and "members" so that the section shall read: "each year one delegate for each fifty voting members and one delegate for each additional major fraction thereof."

Is there any discussion on this motion?

R. J. Armstrong, M.D. (Kalamazoo): Will someone kindly tell us exactly who the voting members are?

The Speaker: Dr. Foster, will you elucidate on who the voting members of the Society are?

Secretary Foster: It is specified in the Constitution, and it says, for instance, that the retired members do not have a vote. It would seem rather unfair to eliminate from your consideration men to whom you have given retired membership. We have many instances throughout the State where men who are on that list attend medical meetings religiously. They are always present. They just aren't practicing, but they want to keep the contact, and they are just as valuable to those societies, particularly the smaller groups, as the members who are in active practice. They have been in active practice but probably for some disability or something of that kind, they have been forced to accept retired membership, and had they been in long enough, they would have emeritus memberships with the same contribution—but still they have no vote.

T. K. Gruber, M.D. (Wayne): Mr. Speaker, I will insert "retired and voting members," with the consent of my second.

Voice: Agreed.

The Speaker: The word "retired" has been included with the word "voting" and the consent has been given by the delegate who seconded the motion. Now it reads: to insert the words "voting and retired" in the section.

T. P. Wickliffe, M.D. (Houghton-Baraga-Keweenaw): I am a freshman at this medical meeting, and I have enjoyed it very much —the House of Delegates meeting. I enjoyed the way in which Wayne County takes care of us and carries on. They are doing a good job for us.

I can see no reason why this great body of delegates should object to an associate member being represented. I am sure they couldn't do any harm to the proceedings of the House of Delegates. I see no reason to change this by law. There will never be more than one or two delegates represented as associate members, and if they are interested enough to be associate members of our Society, I think they should be represented in our House of Delegates without any injury or influence on what we might do.

R. W. Teed, M.D. (Washtenaw): Mr. Chairman and Members of the House: The first sentence in Section 1 reads:

"The House of Delegates shall be composed of Members elected by The Component County Societies."

All of these members that are elected to membership in the component county societies have been elected because they came under the rules governing such election. Consequently, if the County Society feels that these men warrant election, they should have representation, and certainly that applies equally to interns who will at some time undoubtedly be members of the Society and therefore need representation.

It is a question of taxation without representation. If we are going to elect them to membership, we should allow them representation.

The Speaker: Before I grant the floor to Dr. Bailey, who asked for it, I would like for Dr. Spalding to list for us the implications of this wording—who would be included under "voting and retired" according to the new Constitution.

E. D. Spalding, M.D. (Wayne): This is also according to the old Constitution, because it hasn't been changed.

Chapter 5. Membership and Classification of Membership. This has been inserted in different places, but the gist is exactly the same.

All Active Members have a vote, of course.

Honorary Members shall be without the right to vote.

Associate Members shall have no right to vote.

Retired Members shall have no right to vote.

Members Emeritus shall have all the benefits and privileges of membership.

A Nonresident Member shall not have the right to vote.

A Life Member has the right to vote.

Summarizing this, Active Members, Emeritus and Life Members have the right to vote, but Associate Members and Honorary Members do not.

The Speaker: Dr. Bailey asked for the floor. Do you care for the floor, Dr. Bailey?

As it now stands, it will be Active Members, Emeritus Members, Life Members and Retired Members.

L. J. Bailey, M.D. (Wayne): I disagree with those, including Dr. Foster, who feels that others than these voting members should be allowed representation on this floor. They do not have repre-

sentation in their component societies. Therefore, I see no reason for giving them representation here.

Dr. Foster stated earlier in this discussion that members mentioned in the Constitution who were allowed representation in the House of Delegates were voting members. I see no reason for changing that sentiment.

THE SPEAKER: Any other discussion?

T. K. GRUBER, M.D. (Wayne): I think if we allow the Associate Members, Wayne would have quite an advantage. I think probably Washtenaw would have quite an advantage. There are a lot of them that aren't in residence in Wayne County—several hundred of them. I see no reason why nonvoting members or nondues-paying members, in the Associate Membership class, should be used to swell your number of Delegates. Wayne has not practiced that. We have not reported our Associate Members, and that general type of membership, in computing the number of members that are from Wayne County to determine the number of delegates. I think it would be an unfair advantage.

I certainly hope that this motion passes.

THE SPEAKER: Any further discussion?

R. A. SPRINGER, M.D. (St. Joseph): It seems to me that we are eliminating a lot of men from rendering service to our Society by taking away their right to vote and hold office.

For instance, under Associate Members, in the Handbook, as the Constitution now stands, you have a category of Active Members, and it says: "by transfer, for the period of time they are temporarily out of active practice on account of protracted illness." They don't have the right to vote or hold office.

There are a lot of men who have a protracted illness that are not bedridden, and have the time to carry on the business of this organization or of their county organization, and it seems to me that it is unfair to them, and to the retired members perhaps, to prevent them from voting and holding office. There are many times when that individual, as I have said, has time to do things that the man in active practice hasn't the time to do. I think that before we go on, we should give some consideration to those two particular types of memberships.

THE SPEAKER: Is there any further discussion on this question?

PRESIDENT LEDWIDGE: Certainly Associate Members should have no place in the vote. In the first place, they haven't been in there long enough to know what is going on. Many of them are temporary members and will never become permanent members of our Society. In the second place, if the Retired Member wants to be active, he should not retire. It is not compulsory.

THE SPEAKER: As the motion stands now, it is that Voting and Retired Members be considered. That is Active, Emeritus, Life and Retired. Is there any further discussion? Are you ready? If you vote "yes" you will vote for giving recognition in determining the number of delegates to Active Members, Emeritus Members, Life Members and Retired Members.

If there is no further discussion, all in favor of this proposed amendment to Chapter 8, Section 1, say "aye"; opposed, "no." The motion is passed. Therefore, Chapter 8, Section 1 stands as amended.

Now the question before the House is whether the Constitution as published a year ago, with minor changes this year, and the By-laws as amended today, shall be adopted. Is there any further discussion on the main motion?

If not, all in favor say "aye"; opposed, "no." The motion is passed by more than two-thirds vote.

Dr. Spalding, do you have any further report from your Committee?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker—

THE SPEAKER: Do you have a point of order, Dr. Gruber?

T. K. GRUBER, M.D. (Wayne): No. I would like the privilege of the floor for a minute.

THE SPEAKER: You may have the privilege of the floor.

T. K. GRUBER, M.D. (Wayne): A man had an automobile he wanted to sell for $100. He couldn't sell it. A salesman came along and said, "I will sell it." He told him what a great car it was. He was going to sell it for him at $500. The man decided, "I had better keep it myself."

The things that have been said about me, I should keep to myself.

I just want to say that I didn't do this revision. This was a committee composed of Dr. Foster, Dr. Ledwidge, Dr. Holmes and Dr. DeTar and Mr. Herbert, our General Counsel. We had many meetings, and much correspondence, and the meetings lasted until long hours. I want them to have recognition for the good work that they did and for the zest and effort they put into this thing in trying, we will say, to streamline our Constitution and By-laws and bring them up to date.

I just want to thank the Committee. I want to say I did very little of the work. I sat quietly and said "yes." They made the suggestions.

THE SPEAKER: Gentlemen, on behalf of the Committee, I should like to say that we did work hard all right, but the Constitution had to be written by some one person, and that one person was Tommy Gruber. He did the major portion of the work, and it was a terrific job.

While we are at it, I should like to throw a few bouquets at Dr. Spalding and his Committee. They worked hard and did a very good job. On his Committee were Dr. Allen of Bay City, Dr. Day of Jonesville, Dr. Kane of Muskegon, Dr. Reveno of Detroit, and Dr. Strong of Ontonagon. They did an excellent job.

Dr. Spalding, do you have further business to present?

DR. SPALDING (Wayne): Another matter is a petition, not a resolution, which was introduced by Dr. Babcock of Wayne. It is very short. I will read it to you.

XII—g. CREATION OF 17th & 18th COUNCILOR DISTRICTS

"PETITION

"Under the present organization of the Councilor Districts in the Michigan State Medical Society, Wayne County with 43 delegates out of the total of 118 (or 36 per cent of delegates) comprises the First and Sixteenth Districts, and therefore has only two Councilors out of the total of sixteen (or 12½ per cent of the Councilors). Therefore, the Wayne County Medical Society hereby petitions the House of Delegates of the Michigan State Medical Society to subdivide the present First District into the First and Seventeenth, and the present Sixteenth District into the Sixteenth and Eighteenth, each with a Councilor of its own. This will make a total of four Councilors for Wayne County out of a new total of 18 (or 22.2 per cent of the Councilors), representing 36 per cent of the delegates."

The ratio as it now stands in your body, one per cent of the councilors represents three per cent of the delegates in Wayne, but one per cent of the councilors represents one per cent of the delegates in most of the places. This would only bring Wayne up to 1½ per cent instead of one per cent.

This is the petition and the reason for it. The Committee feels that this is a matter to be decided by the House and the Committee itself has no recommendations.

THE SPEAKER: What is your motion as to the disposition of this resolution? You move what?

E. D. SPALDING, M.D. (Wayne): The Committee has no recommendation, but to bring it before you, I move the granting of this petition.

THE SPEAKER: The granting or acceptance of this petition has been moved.

H. W. WILEY, M.D. (Ingham): I second the motion.

THE SPEAKER: Is there any discussion?

Passage of this would be approval of the petition or resolution. Is there any discussion?

L. W. GERSTNER, M.D. (Kalamazoo): I would like the opinion of The Council in regard to this petition.

THE SPEAKER: Would you like to call on any member of The Council?

L. W. GERSTNER, M.D. (Kalamazoo): I wish that one of the Councilors would volunteer.

THE SPEAKER: May we have an expression of opinion from one of the Councilors?

C. E. UMPHREY, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: I think probably this suggestion originally came from me. I am Councilor from the First District, as you know and during the course of business in Wayne I know that some of you know that our Council meets every two weeks. There is a vast amount of business going through the hopper. We have about fifty committees there, and occasionally The Council would encounter new business or something that had been done by the State Society and would turn to the Councilor and say, "What happened?"

This happened a couple of times last year, and I happened not to be on the Executive Committee and was unable to give them the information. They feel that if they have a little greater representation and solidify, this information perhaps would be forthcoming, inasmuch as they carry a seat on the Wayne County Council.

That is the major thing. They want to co-operate. They want to make their work conform with the work of Wayne and the measures that have been passed by the State Society. They want to be influenced and controlled by what the State Society does. It will save some embarrassing moments.

I am very much in favor of this, as a Councilor, and I think that the representation as here denoted will be much more in keeping with the membership of Wayne.

THE SPEAKER: Is there any further discussion on the resolution?

If not, all in favor say "aye"; opposed, "no." The Chair will ask for a rising vote. All in favor will please rise. Will you please be seated? All opposed to this resolution will please rise. It is obvious that this resolution is passed.

Dr. Spalding, do you have further business to bring before the House?

PROPOSED REDUCTION IN TERM OF COUNCILORS

E. D. SPALDING, M.D. (Wayne): There is one more thing in the folder. This is the resolution which was presented on the floor by Dr. Walls. There was some discussion from many quarters as to whether or not the Councilor term might be too long, and also as to whether it was advisable to have Councilors re-elected indefinitely, if their constituency so desired. The resolution is very short.

"WHEREAS, The councilorship in the Michigan State Medical Society is now five years and continued re-election possible; and

"WHEREAS, A longer term of service may make an undue demand on members who have served their local societies long and well; therefore be it

"RESOLVED, That the By-Laws be amended so that a councilorship be of three years duration rather than five and no councilor may succeed himself but once."

That was discussed at length in the Committee, and we had the advice of members of The Council in that Committee, and both parts of this resolution did not seem advisable to the Committee—unanimously. Therefore, the Committee disapproves both of the change in duration of the term of the Councilorship, which is now five years, and also of any limitation on the number of times that a Councilor may be elected.

I move the disapproval of this resolution.

THE SPEAKER: Is that motion seconded?

F. A. WEISER, M.D. (Wayne): I second the motion.

THE SPEAKER: Is there any discussion? The motion is for the disapproval of this resolution. If there is no discussion, we will proceed to vote. All in favor say "aye"; opposed, "no." The motion is passed and the resolution is defeated.

IX—p. MOTION TO INSTRUCT THE COUNCIL TO MAP OUT TWO NEW COUNCILOR DISTRICTS

T. K. GRUBER, M.D. (Wayne): Mr. Speaker.

I move that The Council be instructed to map out the two new Councilor districts in Wayne.

W. S. REVENO, M.D. (Wayne): I second the motion.

THE SPEAKER: You have heard the motion, which has been seconded by Dr. Reveno of Wayne. Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is carried.

Dr. Spalding, is there further business from your Committee?

E. D. SPALDING, M.D. (Wayne): No, I move the report of the Committee as a whole, both as to Constitution and By-Laws and Petition and Councilors' terms be accepted.

THE SPEAKER: You have heard the motion. Is there a second?

E. D. KING, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." Motion is passed.

Thank you very much, Dr. Spalding.

XII—e. CONSULTATION OF DOCTORS OF MEDICINE WITH OSTEOPATH

The next order of business is the Report of the Reference Committee on Resolutions. Dr. Bromme.

Dr. Bromme was congratulating himself last night on being all through work.

Gentlemen, I asked for new business this morning, and no resolutions were presented. I understand there are other resolutions. However, those resolutions will have to be referred to some committee for reference, so when we are through with our morning's business, if anyone has a resolution, the floor will be open to you.

WILLIAM BROMME, M.D., (Wayne): A resolution presented by Macomb County was discussed yesterday evening, and it was suggested by the Chair that recommendations from the floor be received by this Committee, to which the resolution was referred for reconsideration.

This resolution is as follows:

"RESOLVED, That the Macomb County Medical Society desires to have clarified the status of consultation of Doctors of Medicine with Osteopaths on serious cases, and the question of Doctors of Medicine professionally visiting their patients who have been taken to an Osteopathic Hospital as an emergency case, when their condition is such that transfer to another hospital is not advisable."

The Committee thought, and still thinks, that this is not within the purview of the Committee, but acting on the insructions of the House of Delegates last evening, the Committee has the following comment to make:

"This resolution calls for the clarification of an intangible situation. This matter is covered, contrary to the statements by a member of the House yesterday evening, in the June, 1948, revision of the Code of Ethics of the American Medical Association, which was the impression of our Committee in its original report.

"The Code of Ethics states in Chapter 2, title, Duties of Physicians to Their Patients, Section 1, labeled Standards, Usefulness, Nonsectarianism:

" 'In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness to the same end he does—"

(Dr. Bromme continued reading from the Code of Ethics concluding with the phrase—

"—in the same degree in which it elevates the honor and dignity of the doctor in training and practice.' "

(The copy from which Dr. Bromme read was not included in the file of the committee.)

It was suggested from the floor yesterday evening that this was a matter to be handled at the local level. Your Reference Committee feels that if this matter could be handled at the local level this resolution would never have been presented to the House of Delegates.

The recommendation of your Reference Committee on Resolutions is that this resolution be referred to The Council of the Michigan State Medical Society, and I so move.

THE SPEAKER: You have heard the motion. The motion is that this resolution be referred to The Council of the Michigan State Medical Society. Is there a second?

L. J. BAILEY, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion on this maneuver?

H. W. WILEY, M.D. (Ingham): Mr. Speaker, it seems to me that we should ask The Council to take some action on it. I think it is time you did something about this.

THE SPEAKER: The suggestion has been made that The Council take some action. Do you care to propose any amendment to the original motion? Do you care to ask for action?

H. W. WILEY, M.D. (Ingham): I would like to amend that, that they be asked to take some action.

THE SPEAKER: The amendment has been proposed that The Council be asked to take some action. Is there support for that?

T. Y. HO, M.D. (Clinton): I second it.

THE SPEAKER: Is there any discussion on the amendment, that The Council be asked to take some action?

R. A. SPRINGER, M.D. (St. Joseph): Immediate action.

THE SPEAKER: That is a suggestion—immediate action. The Council can't meet before noon.

W. S. REVENO, M.D. (Wayne): Mr. Speaker and Members of the House: I think rather than to leave the matter as has been suggested, I would like to make even a little more specific instruction by amending the amendment, to the effect that the resolution be referred to The Council of the Society with the suggestion that they in turn refer the matter to the Committee on Ethics for adjudication or for a ruling.

THE SPEAKER: The amendment to the amendment is that the stipulation be given to The Council that after consideration the whole matter be referred to the Committee on Ethics of the Michigan State Medical Society for ruling. Is there any support to that amendment?

F. G. BUESSER, M.D. (Wayne): I second it.

THE SPEAKER: Is there any discussion on the proposed amendment to the amendment?

T. K. GRUBER, M.D. (Wayne): My comment may not be exactly on the amendment to the amendment, but my comment is on the report that Dr. Bromme read.

The excerpt from the ruling of the Judicial Council of the American Medical Association is very fine verbiage. I don't believe that even the great Judicial Council of the American Medical Association could interpret it. I don't believe the American Medical Association has gone into the matter and really brought out a ruling on the subject that is worth while.

I don't want to have Dr. Bromme read it again, but I think if you would listen carefully to it, when you got through you would be right where you started. I think it is a very foolish presentation that the Judicial Council of the American Medical Association has made, and they have ducked the issue.

THE SPEAKER: Is there any further discussion on the amendment to the amendment?

C. I. OWEN, M.D. (Wayne): This is just a short discussion on the subject. We are in Delegates' Session. The Council acts in our absence. It is much less representative of the profession than this group. I don't believe we ought to pass the buck to The Council.

THE SPEAKER: Is there any further discussion on the amendment to the amendment?

If not, we will proceed to vote on the amendment to the amendment, which is to the effect that The Council be instructed to refer this to the Ethics Committee. If you vote "yes" you will vote for The Council to refer it to the Ethics Committee.

PRESIDENT LEDWIDGE: May I speak on that?

THE SPEAKER: Yes, Dr. Ledwidge.

PRESIDENT LEDWIDGE: I take it you mean the Ethics Committee of the State Society. What have they to do with it? Are they to have full authority to decide it? After all, they are a committee of The Society. Are they to be given full authority? Otherwise they will refer it back to The Council for further discussion.

THE SPEAKER: Is there any further discussion?

S. L. LOUPEE, M.D. (Cass): We are told that The Council is the executive body of this organization, and so it is. As such, it is its policy to execute the orders given by the House of Delegates. The House of Delegates at this very moment seems not to have the determination to make a decision which is in our lap. I think the decision should come from us, and leave the execution of it in the hands of The Council.

THE SPEAKER: If you are in favor of referring this to The Council to be referred to the Ethics Committee, vote "yes." If you are opposed to that particular vote, vote "no." Any further discussion?

L. C. HARVIE, M.D. (Saginaw): The Ethics Committee can make no decision. It is only a fact-finding committee and must refer its findings back to The Council, so I see no purpose in referring it to the Ethics Committee.

D. C. BLOEMENDAAL, M.D. (Ottawa): The thing we are discussing happens every day. A patient goes to a Doctor of Medicine and then goes to an Osteopath. I don't think we have to get so stewed up about it. It happened not long ago in our county. A man refused to go out or couldn't go out, and the patient went to an osteopath and got along all right, and nothing more was said about it. So I don't know whether we know all the facts about this local problem. I don't know whether the House of Delegates should act on this or not. I feel that it is more or less a personal problem and if the Osteopaths are that much better than the regular physician, let the patient go to the Osteopath. That is the way I look at it.

THE SPEAKER: Is there any further discussion?

Gentlemen, I will ask you to limit your discussion to the amendment to the amendment. That is all we are discussing now—whether this should be referred to the Ethics Committee or not. Of course, if you pass the amendment to the amendment it will carry the amendment and the motion. In other words, the entire resolution will be referred with instructions.

D. B. WILEY, M.D. (Macomb): I happen to be the one who presented this resolution on behalf of Macomb County. Possibly my

remarks are not entirely on the amendment to the amendment. If I am in error, I expect the Speaker to correct me.

THE SPEAKER: That is all right. Go ahead.

D. B. WILEY, M.D. (Macomb): However, probably there are some further explanations that are due the House. They have been given to the Committee on Resolutions, and notwithstanding the remark of the Chairman, that this was a local problem, we do not feel that this is a local problem, in Macomb County.

Macomb County has approximately fifty-six Doctors of Medicine and thirty-three Doctors of Osteopathy. Let's refer to them as osteopaths. In that proportion, the percentage of Wayne County would be well over 1200, and the number in the State of Michigan would be approximately 3000.

There is no question but that all of our every-day practice is tied up with ethics. However, this probably should be considered as a matter of policy also.

If it is in the power of the House of Delegates to determine what should be done with such a problem, if it is their desire, they may pass this on to The Council, which is the executive body of the House of Delegates, to consider these matters between the annual sessions of the House of Delegates, but as far as Macomb County is concerned, we have no particular trouble with our own members but we do not have any jurisdiction over members of the other county societies, who may come into Macomb County and act in the osteopathic hospitals.

Probably there are similar circumstances throughout the state, perhaps not to the same extent that there is in Macomb County. Let's hope that there is not and will not be any such influx throughout the state as there has been in our own particular county. Thank you.

THE SPEAKER: Thank you, Dr. Wiley.

Before we proceed to a vote or further discussion, I am going to ask Dr. Bromme to read the resolution again, in order that you may be sure what you are voting on.

WILLIAM BROMME, M.D. (Wayne): You must realize that the Committee also attempted to obtain clarification of the resolution so there could be a cut and dried question presented to the House instead of a request for clarification.

The resolution is as follows:

"RESOLVED, That the Macomb County Medical Society desires to have clarified the status of consultation of Doctors of Medicine with Osteopaths on serious cases, and the question of Doctors of Medicine professionally visiting their patients who have been taken to an Osteopathic Hospital as an emergency case, when their condition is such that transfer to another hospital is not advisable."

That is the resolution presented to your Committee.

THE SPEAKER: Is there any further discussion on the amendment to the amendment which is what we are discussing now?

PRESIDENT LEDWIDGE: Mr. Speaker, may I ask one point for clarification?

THE SPEAKER: Dr. Ledwidge of Wayne.

PRESIDENT LEDWIDGE: I am not quite clear on all the amendments. Will you read the motion, the first amendment and the amendment to the amendment?

THE SPEAKER: The motion as presented by Dr. Bromme—I will ask him to read the motion.

WILLIAM BROMME, M.D. (Wayne): The motion was that this resolution be referred to The Council of the Michigan State Medical Society.

THE SPEAKER: Thank you. The amendment to the motion was that it be referred to The Council with instructions to act, and the amendment to the amendment was that The Council be instructed to refer the matter to the Ethics Committee. We are now voting on the amendment to the amendment, which would carry the amendment and the motion. In other words, if the House of Delegates does not care to decide this matter, it will be referred to The Council with instructions to refer it to the Ethics Committee.

PRESIDENT LEDWIDGE: Mr. Speaker, I still feel that doesn't take care of the matter, because after this has been referred to the Ethics Committee, what from there on? Are they to be voted authority to decide it? Are they to refer it back to The Council? What is going to be done with it?

THE SPEAKER: Is there any further discussion on this matter?

W. S. REVENO, M.D. (Wayne): When I offered the amendment to the amendment, I specified that The Council refer this matter to the Ethics Committee of the State Society for an opinion. That opinion is to come back to The Council of the State Society, and The Council then transmits that opinion to the group inquiring or introducing this resolution.

THE SPEAKER: In other words, gentlemen, if you pass this amendment to the amendment, this will be referred to the Ethics Committee for an opinion. That opinion will be transmitted back to The Council, and The Council will transmit the opinion back to the county medical society in Macomb.

Is there further discussion? If you pass this motion that will be done.

PRESIDENT LEDWIDGE: I still object to it. It is contrary to everything in the working of The Council and the Committee.

THE SPEAKER: You object to what?

PRESIDENT LEDWIDGE: That procedure. I think that should be referred to The Council to use their judgment, with the instructions they have, if you wish, but it certainly should not be referred through The Council to the Ethics Committee and back to the parent body, who has to approve the opinion of the Ethics Committee rather than give it to the Ethics Committee and let them approve it.

THE SPEAKER: If you agree with Dr. Ledwidge, you will defeat the amendment to the amendment. If you do not agree with Dr. Ledwidge and want it referred indirectly to the Ethics Committee, you will vote "yes." If you vote "yes" before The Council, it goes to the Ethics Committee. If you vote "no" we will consider the amendment and the original motion.

All in favor of the amendment to the amendment say "aye"; opposed, "no." The amendment to the amendment is defeated. The question before the House now is the amendment, that the resolution be referred to The Council with instructions to act. Is there any discussion on this amendment?

If not, all in favor say "aye"; opposed, "no." The Chair will ask for a raising of the hands. All in favor of this amendment will please raise their right hands. If you vote "yes" it is to be referred to The Council with instructions to act. All opposed to this motion will raise their right hands.

This motion on the amendment has carried 53 to 37. It is not necessary to vote on the motion because the amendment carries the motion, and the resolution will be referred to The Council with instructions to act.

Dr. Bromme, do you have any further business?

WILLIAM BROMME, M.D. (Wayne): We have one resolution, sir. That is the resolution presented yesterday evening by Dr. Barone—

XII—e. TO INCREASE NUMBER OF MEDICAL GRADUATES

"RESOLVED, That the Michigan State Medical Society, through its Officers, initiate a movement to increase the number of students graduated from the medical schools in this State and that the Delegates to the AMA initiate a similar movement on a national basis, to increase the number of physicians graduated and that the Delegates to the American Medical Association initiate a movement to establish new medical schools in those states where none now exist."

The Reference Committee went over the preamble to this resolution with considerable care, because there were a number of loose statements in it which are not supported by facts, and the preamble to a resolution must contain facts on which the conclusion can be based.

One statement is to the effect that the Ewing Report states that there is a 20 per cent shortage of physicians. There is no copy of the Ewing Report available. That is a report culled from a newspaper, from a report submitted by Mr. Ewing, the Federal Security Administrator. We think that is a very sketchy basis on which to formulate a decision of this body.

There is another statement—

"WHEREAS, The present curbing of graduates and/or admission is due to postwar regulations and controls of the American Medical Association."

That is information which is not subject to proof or disproof by the Committee, so the Committee rewrote the preamble and the resolution and submits it as an alternate resolution.

"WHEREAS, There is general agreement as to the need for a larger number of physicians and

"WHEREAS, The facilities for teaching are not sufficiently increased to provide hope in the near future of answering the need for a larger number of physicians, and

"WHEREAS, The number of individuals other than Doctors of Medicine licensed to practice the healing art in the State of Michigan has increased materially, therefore, be it

"RESOLVED, That the Michigan State Medical Society, through its officers, support any reasonable means to increase the number of students graduated from medical schools in this State, and that the Delegates to the American Medical Association take similar action at the next meeting of the American Medical Association House of Delegates."

Mr. Speaker, the Reference Committee on Resolutions proposes that this alternate version of the resolution be considered by the House, and I move its adoption.

THE SPEAKER: You have heard the motion. Is it supported?

O. K. ENGELKE, M.D. (Washtenaw): I second the motion.

THE SPEAKER: Is there any discussion on this motion to approve the resolution as amended by the Committee?

If not, all in favor say "aye"; opposed, "no." The motion is passed.

Do you have any further business Dr. Bromme?

WILLIAM BROMME, M.D. (Wayne): Mr. Chairman, this completes the resolutions as presented to the Resolutions Committee. I move the acceptance of the report of the Resolutions Committee as a whole.

THE SPEAKER: Is that motion supported?

E. D. KING, M.D. (Wayne): I support it.

THE SPEAKER: Is there any discussion? If not, all in favor say "aye"; opposed, "no." Motion is passed.

WILLIAM BROMME, M.D. (Wayne): Mr. Speaker, may I take this moment to thank very much the personnel of the Resolutions Committee. None of us had worked together as a Reference Committee before. Some of us are neophytes to the problems of Reference Committee work, and certainly I am very happy to have had Dr. Carpenter, Dr. Fenton, Dr. Harris, Dr. Holtom, Dr. Kullman and Dr. McKean on this Reference Committee.

THE SPEAKER: Thank you, Dr. Bromme.

I should also like to assure Dr. Bromme that I don't believe he is through work.

With the permission of the House, the Chair would like to refer back to New Business and ask if there are any other resolutions that any delegate cares to present this morning.

IX—q. HOUSE OF DELEGATES RESOLUTIONS TO BE PRESENTED 30 DAYS PRIOR TO SESSION

H. H. Riecker, M.D. (Washtenaw): May I apologize for offering a resolution at this late time. This resolution concerns resolutions.

"WHEREAS, Many resolutions presented to the House of Delegates at its Annual Session should receive more adequate consideration than time permits under the present procedure, and many implications arising in association with these resolutions require consultation with officers and members of the county societies before a truly representative opinion can be formulated, therefore, be it

"RESOLVED, That all resolutions to be presented to the House of Delegates in Annual Session be delivered to the Secretary of the Michigan State Medical Society not later than thirty days prior to the date of the meeting. Further, that copies of all such resolutions be forwarded by the Secretary to the secretaries of component units of the Society as well as the officers and appropriate committees for their consideration prior to convocation of the House of Delegates.

"The action proposed in this resolution is to be considered as a ruling of procedure and not an amendment to the By-Laws."

The latter is put in there so if the House accepts this and desires to change it later, that can be done.

The Speaker: You have heard the resolution. The Chair will refer this to the Reference Committee on Resolutions.

Dr. Bromme wishes the floor.

William Bromme, M.D. (Wayne): The only reason the Chairman of the Committee on Resolutions stuck out his neck and let Dr. DeTar open the gate for this was because we knew this resolution was on the way. The Committee saw it last night and discussed it, and has an action to present, if you will accept the supplemental report of the Reference Committee on Resolutions at this time.

The Speaker: This is probably the first time on record that a Reference Committee has ever considered a resolution before it was thought up.

If there is no objection on the part of the delegates, we will consider the report of the Reference Committee at this time.

William Bromme, M.D. (Wayne): As a matter of fact, we saw this in time. The only formality was that it had not been presented to the House of Delegates, so the Committee did not feel that it was jumping the gun in seeing something which was already in published form.

The resolution is proposed by Dr. Riecker—

"Resolved, That all resolutions to be presented to the House of Delegates in Annual Session be delivered to the Secretary of the Michigan State Medical Society not later than 30 days prior to the date of the meeting. Further, that copies of all such resolutions be forwarded by the Secretary to the secretaries of component units of the Society as well as the officers and appropriate committees for their consideration prior to convocation of the House of Delegates.

"The action proposed in this resolution is to be considered as a ruling of procedure and not an amendment to the By-laws."

This resolution bears the approval of your Resolutions Committee, and I move its adoption.

The Speaker: Is that motion supported?

R. L. Wade, M.D. (Branch): I second it.

The Speaker: Is there any discussion on the motion to adopt the resolution?

L. W. Gerstner, M.D. (Kalamazoo): That eliminates one-twelfth of the year in the deliberations of any one county society. I can conceive that the problem of a resolution is going to arise during the year. It may arise the first month, the second month, or the third month. This is a new one. I hadn't thought it over. I can conceive its arising in the last month and depriving that component society of presenting that resolution which arose in the month preceding this Annual Meeting, were it to be made a rule.

H. H. Riecker, M.D. (Washtenaw): Will you read the last paragraph of the resolution?

William Bromme, M.D. (Wayne): You omitted the last paragraph, so I did, too.

H. H. Riecker, M.D. (Washtenaw): I didn't know the question would come up. So maybe we had better go ahead.

The Speaker: The question arises whether the resolution is as printed or as given verbally. Dr. Riecker has asked that the last part be read. We are not voting on the last paragraph at present, because the motion has been made that the resolution be adopted as read.

With the permission of the House, I will ask Dr. Bromme to read the last paragraph for consideration.

William Bromme, M.D. (Wayne): "This ruling does not preclude the presentation of a resolution during a session of the House of Delegates if its urgency is agreed upon by the President of the Michigan State Medical Society, the Secretary, and the Speaker of the House, acting as a committee."

That also was agreeable to the Resolutions Committee.

The Speaker: Before we go ahead with any additional discussion—and this is simply considered as a suggestion which could be made as an amendment if anyone cares to propose it, I would like to ask the Secretary of the Society to tell us his opinion on this, because he has been wrestling with this problem for years.

Dr. Foster!

Secretary Foster: I, too, saw this resolution last night and was surprised when the last paragraph was not read, because it is perfectly obvious that there are emergency situations, that could arise in the last month, and that the provision would have to be made whereby somebody could give the opinion that they were emergencies and have them presented.

As a matter of fact, this same procedure, to a certain extent, is followed in the American Medical Association. It was felt here, in the original draft of this as presented, when it was first shown to me, it was said that the Secretary of the State Society should get these resolutions thirty days prior to this meeting and that he should then transmit them to the delegations and the Chairmen thereof.

I can assure you, gentlemen, that in the last thirty days prior to this meeting it would be quite impossible for the Secretary of the State Medical Society to know who the chairmen of the delegations of fifty county societies would be, and it was my suggestion, if it was a question of information to be gotten to the various groups, it would be much more practical to have the resolutions presented thirty days in advance, have them mimeographed in the executive office and transmitted to the fifty-five county secretaries, who in turn were in close touch with their delegations and their societies, and they could much better and much more practically transmit the resolutions to those people who were interested in studying the provisions thereof.

The Speaker: Is there any further discussion?

Dr. Gruber, I am sorry. Dr. Babcock of Wayne asked for the floor. However, if you take the floor now, he can be coming to the platform.

T. K. Gruber, M.D. (Wayne): I am convinced that this is a very impractical suggestion. The Wayne Delegates are elected at the last meeting in May, and from then on until fall they are away on their vacations and various things, and there are no meetings held during the summer.

About a month ago we convened the delegates to see what ideas they had. We appointed committees to sort them out. We had three meetings. The last was Friday last, at which the resolutions to be presented by the Wayne Delegation were formulated and agreed on by the Wayne Delegation.

If we have to get those resolutions in thirty days ahead of time, it is going to be a hardship, and I think you will find that each county society is in about the same shape. We are all procrastinators. After all, the problem comes down finally to the place that you get your ideas on paper.

At the American Medical Association, they don't bring them in. They present them on the floor of the House.

There are many controversial subjects that the county societies have. They don't want the discussion beforehand. They want to bring it down and spring it as a surprise. That is one of the things that the human race likes to do.

I certainly hope we will not pass this resolution.

W. W. Babcock, M.D. (Wayne): Dr. Gruber has brought out many of the points that I wanted to bring out. I merely wish to implement those. I feel that passing this resolution would definitely take away the prerogatives of the delegation and would weaken the voting power of this democratic assembly.

The Speaker: Is there any further discussion on the motion?

H. H. Riecker, M.D. (Washtenaw): I have been a delegate here for about five years, and during that time, every year there have been certain questions brought up in resolutions which I would like to talk over with someone in my own county, and all the other delegates in my county—there are only five of us—have that same opinion. We would like to have a little more time in which to consider some of these things, which in certain cases affect our county vitally. There are one or two in this meeting which do.

It is to my mind more democratic to give us a chance to get the opinion of the leaders in our county societies, the men concerned in certain problems. When they are brought on the floor of the House so suddenly, we have no time to telephone to Ann Arbor or Ypsilanti or Milan, or wherever it is, to find out the opinions of the men and to get their advice that we need so badly before we vote on the resolution.

The whole point is, to my mind, to make the thing more democratic, to give a broader base upon which to make it, to decide how this resolution is going to affect our community and our state.

Thank you.

The Speaker: Dr. Riecker, do you care to propose any amendment to make this a little more elastic, so business can be brought up in thirty days? Your last paragraph was not included in the resolution.

H. H. Riecker, M.D. (Washtenaw): In formulating this there was a great deal of discussion about the time, thirty days or two weeks. I thought two weeks was enough to have, for the resolutions to be brought to the attention of the local delegations.

I propose an amendment of the last paragraph, Mr. Speaker.

The Speaker: Dr. Riecker moves the adoption of an amendment, consisting of the last paragraph which was not read. I will ask Dr. Bromme to read the last paragraph.

William Bromme, M.D. (Wayne): "This ruling does not preclude the presentation of a resolution during the session of the House of Delegates if its urgency is agreed upon by the President of the Michigan State Medical Society, the Secretary, and the Speaker of the House, acting as a committee."

The Speaker: Does anyone support this proposed amendment?

R. W. Teed, M.D. (Washtenaw): I support it.

The Speaker: Is there any discussion on the amendment?

R. J. Armstrong, M.D. (Kalamazoo): Mr. Speaker, having had the courage to get this far in the front, I am disgusted with this House of Delegates in this Session. I haven't heard half a dozen voices come out and talk. I think you are giving away your prerogatives. If you are going to give this last one away, I think you might as well stay home.

The Speaker: Is there any further discussion on the amendment?

L. C. Harvie, M.D. (Saginaw): Why should any resolution have a board of censors before it is presented before this organization?

The Speaker: Is there any further discussion?

If not, all in favor of the amendment—I think you remember the amendment and I don't need to repeat it—will say "aye"; opposed, "no." The amendment is defeated.

Is there any further discussion on the motion to adopt the resolution? If there is no further discussion on the motion, those in favor of adopting the resolution say "aye;" opposed, "no." The motion is undoubtedly defeated.

Is there any further business, Dr. Bromme?

William Bromme, M.D. (Wayne): The Reference Committee on Resolutions has presented its full report and requests that its report be accepted as a whole and that the Committee be discharged.

The Speaker: Is there a second?

E. G. Krieg, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion? If not, all in favor say "aye;" opposed, "no." The motion is passed.

There is one more Reference Committee I would like to ask for right now, and that is, I would like to know if there is a supplemental report from the Reference Committee on Special Memberships.

J. J. Lightbody, M.D. (Wayne): There is. We will take just a moment.

The Speaker: You may be thinking about this while he is coming up. I am going to ask you whether you would like to recess this session after this report, or whether you would like to get into the Report of the Reference Committee on Ethics.

J. J. Lightbody, M.D. (Wayne): Mr. Speaker and Delegates: There is very little of a controversial nature that our Committee has had anything to do with. Most of our difficulty has been in finding out whether a man is seventy years of age or sixty-nine, or whether his dues have been paid up. I don't think it will take more than a moment here for me to give you the Committee's report.

XII—f. ON SPECIAL MEMBERSHIPS

We have had a few more resolutions for special memberships.

Name	*County*	*Type of Membership*
Lewis Bracey, M.D.	Ionia Montcalm	Life
W. E. Jewett, M.D.	Lenawee	Life
R. W. McLain, M.D.	Jackson	Life
Henry Herzer, M.D.	Calhoun	Life
Charles Heald, M.D.	Calhoun	Life
W. O. Upson, M.D.	Calhoun	Life
Benjamin Franklin, M.D.	Mecosta	Life
C. E. Long, M.D.	Ottawa	Life
George L. Bond, M.D.	Kent	Life
Simeon LeRoy, M.D.	Kent	Life
Burton Corbus, M.D.	Kent	Life
J. R. W. Kirton, M.D.	Houghton	Emeritus
H. Landon, M.D.	Monroe	Emeritus
Joseph Whinery, M.D.	Kent	Emeritus
Frederick Baker, M.D.	Oakland	Retired

Mr. Chairman, I move the adoption of these resolutions for special memberships.

The Speaker: Is that motion supported?

B. G. Holtom, M.D. (Calhoun): I second it.

The Speaker: Is there any further discussion on the motion to grant these special memberships by the adoption of this motion? If there is no discussion, all in favor say "aye"; opposed, "no." The motion is passed.

Dr. Lightbody.

J. J. Lightbody, M.D. (Wayne): There have been a few applications for special memberships which the Committee had to consider, and because of incomplete qualifications and specifications for these memberships, they had to be turned down. I know that some of the resolutions have asked for certain members to have certain types of special memberships.

In case there have been men whose names have been presented to the Committee for special memberships and they have not been brought before the House up to this time, if the delegates will consult me after this meeting I will discuss with them why those men have not been considered for the special memberships, or at least the reasons why they were not approved for special memberships.

Mr. Chairman, I move the adoption of this Committee's report as a whole.

The Speaker: Is that motion supported?

F. G. Buesser, M.D. (Wayne): I support it.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed. Thank you very much, Dr. Lightbody, for your splendid work.

Is there any other business to come before the House?

Gentlemen, the next order of business is the report of the Reference Committee on Ethics. Now I should like to ask the pleasure of the House in this regard. Would you rather have the report of this Reference Committee now? Would you rather meet in an hour and have it, or would you rather consider it in the regular session, which is the meeting convening at eight o'clock tonight?

Will all those who wish to put over the rest of the business of the House until the next meeting at eight o'clock tonight, please raise your hands?

Thank you. That is the majority, and in a moment we will recess. However, I should like to ask if any of the Reference Committee chairmen care to have meetings of the Reference Committees this afternoon. If so, please get a message to me at once.

(Announcements.)

Is there any further business to come before the House?

If not, I hope you all will enjoy the ball game, and I will see you at eight o'clock.

(The meeting recessed at one o'clock to reconvene at eight o'clock the same day.)

Fourth Meeting

Tuesday Evening, September 21, 1948

The meeting convened at eighty-thirty o'clock, J. S. DeTar, M.D., the Speaker, presiding.

The Speaker: The House will come to order.

Dr. O'Meara, are you ready to report?

J. J. O'Meara, M.D. (Jackson):

I have the names of 94 members whose credentials have been signed by the proper officials of the different county medical societies. This, of course, is more than 40 per cent of the accredited delegates, and 50 per cent of which is not from any one individual county.

The Speaker: Thank you, Dr. O'Meara, for your final report. Congratulations for handling it so beautifully.

I am sorry to have to give you this announcement that our Public Relations Counsel, Hugh Brenneman, who became ill last Friday, became much worse today and was taken to Harper Hospital under Dr. Reveno. He is now receiving intravenous treatment and penicillin and he is quite ill. It seems to me that, since Hugh Brenneman rendered great service to us and is a very valuable man, that it would be very appropriate if we would send him some sort of token.

IX—r. MOTION TO SEND BEST WISHES TO PUBLIC RELATIONS COUNSEL—HUGH W. BRENNEMAN, ILL

C. L. Weston, M.D. (Shiawassee): I move that the House of Delegates send a message of regret to Hugh W. Brenneman, accompanied by a huge bouquet of flowers.

The Speaker: Is that seconded?

R. W. Teed, M.D. (Washtenaw): I second it.

The Speaker: All in favor of the motion say "aye"; those opposed, "no." It is carried.

Gentlemen, there was one very short speech made this afternoon that caused me some concern. That was the speech by Dr. Armstrong of Kalamazoo. He came to the rostrum and said he was definitely disappointed in this House of Delegates. He made the suggestion that perhaps the decisions of this House were determined to some extent by the minority of the membership of this House.

As Speaker of the House, gentlemen, I urge the utmost freedom of discussion. Now if the Chair has not provided that freedom of discussion, then my apologies to the House. I hope that every delegate will do his utmost to represent his constituents, not only in the voting but also verbally. I think that is only our duty to the men we represent.

Will the Vice Speaker take the chair and carry on with the agenda?

(R. H. Baker, M.D., Vice Speaker, took the chair.)

The Vice Speaker: The next order of business is Unfinished Business. Is there any other unfinished business to come before this meeting?

Douglas Donald, M.D. (Wayne): Mr. Speaker, does my report come under Unfinished Business—the Report of the Reference Committee on Ethics?

The Vice Speaker: We will get you on the Reference Committees.

Is Dr. Beck here?

Are there any supplemental reports from The Council or from any standing committees?

Is there a report on the Reference Committee for standing Committees?

E. G. Krieg, M.D. (Wayne): None.

The Vice Speaker: Is there any report for the Reference Committee on Special Committees?

G. C. Stucky, M.D. (Eaton): No.

The Vice Speaker: I think the Constitution was closed.

Is there any other report from the Committee on Resolutions?

William Bromme, M.D. M.D. (Wayne): No.

The Vice Speaker: I guess then we are ready for the Report of the Reference Committee on Ethics. There is still some unfinished business left over from this morning.

Dr. Donald.

XII—h. ON ETHICS

DOUGLAS DONALD, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: This Committee on Ethics has received two resolutions. The Speaker promised us there was to be only one, but he did not keep his word.

XII—h. RESOLUTION OF SECTION ON OPHTHALMOLOGY

The first resolution was presented by the Special Committee of the Section on Ophthalmology of the Michigan State Medical Society. This resolution started with a long preamble, followed by the resolution.

Your Committee has surveyed the preamble and has gone on to the resolution, and our report will be upon the resolution.

A great deal of thought was given to this. A long time was given to hearing from the Michigan Ophthalmology Society. Their problems were discussed.

After discussion, your Committee is proposing a revised resolution, which I shall read. This is the resolution as revised by your Reference Committee on Ethics:

"WHEREAS, We propose to continue to conduct the practice of medicine according to the experience and judgment of a responsible medical profession, working from the scientific, sociological, and economic angles according to plans based on experience to increase the distribution of good care,

"WHEREAS, The Michigan State Medical Society is in the habit of looking at its problems squarely, fearlessly, honestly, and by analysis, and

"WHEREAS, After analysis to approach new methods as scientific men should, by planning and experimentation, knowing that the complicated subject of economics in any segment of medicine cannot suddenly be changed by any single formula or law,

"WHEREAS, According to the principles of medical ethics it is unprofessional to accept rebates on prescriptions, appliances or perquisites from attendants who aid in the care of patients, we believe it will be the consensus of the House of Delegates that the membership of the Michigan State Medical Society and of the medical profession in general is as honest and as much to be trusted in all of its responsibilities as any other group of citizens, be it therefore

"RESOLVED, That it is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"That We urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

Mr. Speaker, I move the adoption of this revised resolution from the Ophthalmological Section.

THE VICE SPEAKER: You have heard the motion as revised. Is there a second?

E. D. SPALDING, M.D. (Wayne): I second it.

THE VICE SPEAKER: Is there any discussion?

R. H. PINO, M.D. (Wayne): Mr. Speaker, I think this resolution, as it has been revised by the Committee, covers the subject very well. I think a point has been left out that we had in there, covering any therapeutic agent, that the Doctor of Medicine should be responsible to the patient and be in position to handle that therapeutic agent as he feels best, even if he has to buy, let us say, drugs at wholesale and sell them to the patient for nothing or for a price consistent with the doctor's charges, which we all know are from anything or nothing up to reasonable charges.

I hope that you have read the resolution and the preamble as it was handed out to you. I am discussing this now. I will vote for that resolution as it is suggested.

I think, however, that there is so much misunderstanding that there comes a time when the delegates of the Michigan State Medical Society should have a subject of this type reviewed before them, in order that they may be able to answer some of the problems that arise, for we are dealing here with a subject that has shaken the foundations of medicine in America.

I would not spend time on this if it were a personal matter. It has been nearly ten years since the subject of rebates has affected my practice. I have handled it in another way, from dispensing in the interests of my patients from my office, and that is the way it should be done under the circumstance of all that is included in this great subject. In other words, through the use of medical associates, as one method, we will come to know that if we are going to protect the patient's interest from the standpoint of his glasses, we have to be in position to control that, and I think the resolution calls for it all right.

Let's remember just a few of these things. We are dealing here with statutory law, and we are dealing with ethical law. We are dealing with the distribution of medical care, and we are dealing with the science of medical care.

We have been brought straight up against certain laws, considering this from the standpoint of statutory law, namely the Sherman Act, which was passed around the turn of the century, when Theodore Roosevelt was wielding the big stick, and gradually the Government has been trying to use this. Now, as pointed out in the preamble to the resolution, 65 per cent of the prescribing of glasses is done by the optometrist, in all kinds of places. I do not need to name them, nor to discuss the blinking eyes in the window and things of that type that attract the patients. I hope you will make note of that there.

But what happens? In 1940 the Federal Government lost its suit against the large optical companies. It loses its suits to a very great extent when brought against companies that are sufficiently large; I might say General Motors. I am not sure that any suit has been brought against General Motors for obstructing the distribution of automobiles, but that is a little bit too big to handle.

Now they lost this suit. Let me make this statement. I am absolutely for the Federal Government in this case, and so are all of the other ophthalmologists who know about it. I am for them from the standpoint of rebates, for rebates have come to be considered an accessory to collusion in monopoly. Let me say this, that by consent decree rebates will be out in the United States shortly.

Having lost their case, this is what happened. They said, "Well, what accessory to this can we find?" And so it turned out that they could pick out about fifteen per cent of those who prescribe glasses and attach them to the suit, which they have done, wherever they could get that.

I said a few minutes ago that not since 1940 have I dealt in this from the rebate standpoint, which I uphold, or have up to such time as different arrangements can be made for a reason which I can tell you. But I bring this to you as what will be the case in event medicine is taken over by the Federal Government. You will be subservient to a police type of thing that you are not in the habit of having, and I want to give one illustration.

The Government went into the records of the optical company, that is concerned in the current suits, and there they found that two patients of mine in the time covered by these suits had taken their prescriptions. I am not certain just where they were, but I understand that one was in the State of Nevada and another I think in Nebraska. At any rate, I have the letter that I could read to you, but I will not take the time. One of these was for five dollars and something and another was for another amount. The sum total was $10.50.

To show you what public opinion can do, one morning I woke up and went down to breakfast, and here was the paper with my name spread across it, and I went down to the hospital and turned on the radio and again listened—I was one of seven men in the State of Michigan who had cost the people millions of dollars.

That is all right. I can stand that. I can get along without anything that has to do with glasses. I have gotten that far, and I think after another ten years I will have enough so that maybe I will have $300 a month for the rest of my life, but I am concerned about some of the young men who will not have to have rebates but who need some consideration in this from this House of Delegates, and I mean some sympathetic concern.

What happened? At the time that I went with Dr. Robb in 1918, we charged $3 for an eye examination. He had been with Dr. Donald Campbell, who charged $3, except for someone who maybe belonged to the D.A.C. or lived in Grosse Pointe, and maybe they charged $5 then.

How could they do it? They could do it because they made something on this commodity, 85 per cent of which was being handled by the optometrist, and on which they were making money and holding up the price.

One day I said to Dr. Campbell, "Dr. Campbell, I have just come from a meeting where they said it is wholly unethical to do that."

"Yes," he said, "young man, I know, but if you want to start in practice in Detroit, and if you want to fix it so that the people can't afford to come to you, as it is in New York where they charge at this time $10 to $25"—and now they charge from $25 to $50—"for an eye examination and most of your patients go to the free clinics, if you want to do that, then don't have anything to do with glasses at all, and let your patients go to the basement of Crowley & Milner and to Square Deal Miller"—and now as it is to Frank & Seder. Frank & Seder, in the drygoods business, are putting out advertising now. They want these prescriptions.

If you read more in that preamble, you will notice this, that glasses in quality range anywhere from the best, made by the highest, well-paid workmen, to those you can buy in the dollar store, and when you think of this thing, if you will notice, those of you who wear glasses, there are many times you get glasses you can't wear at all, and then there are some you can wear. Eighty-five per cent of this business is done by the optometrists.

According to some of the recent rulings—I will say rulings by public opinion—the public has been told that we should write the prescription and give that to the patient and let him go where he will. Why? In order that there might be a distribution of the business and in order that competition may bring the cost down. So we have.

Frank & Seder—I have nothing against Frank & Seder. These companies are all out after business. The Better Business Bureau comes in for its name and to make something for itself, particularly for those who run it, and so in two states the Better Business Bureau has come in and has said—they have repeated what the AMA has said—you can't blame them any—that we are parasites. Here it is in the JOURNAL, put out so that all who will may read it. Gentlemen, you can't blame the newspapers. You can't blame the *Readers' Digest*. You can't even blame the Better Business Bureaus,

although the majority (all but two states) have said, "Well, if it is this important we will leave it to the Federal Government to settle."

We said it was a problem of ethics as far as the AMA was concerned. Without their ever having gone into the facts, they have come out and said, "Yes, it is against our ethics for one to receive rebates." But is there not something else to this?

The American Medical Association waits for the Michigan State Medical Society and other societies to give the leadership, but they turn us over to the newspapers and to the Better Business Bureaus. Though the American Optical Company is dealing with 85 per cent for whom they care, they do not care about us at all. If you do have the exhibits that are referred to in that preamble there, you would know.

I have it right here, and this is in our better magazines. They go on to say: "Professional and technical services such as those illustrated are essential aids to seeing ability." Then note: "Will glasses only improve your sight?" Now they are discussing here the subject. They are taking a group of stenographers this time. "You, too, like the stenographer, should have seeing ability to meet your visual requirements. As in the case of some other stenographers, you may not be able to achieve this unaided. The only way for anyone to make sure is to seek professional guidance. Important as glasses are, their aid to your visual comfort and efficiency depends upon the professional and practical service of—" Who first? The optometrists, with whom they do 85 per cent of their business, and the Federal Government should get after them, and it is doing it, because the vast majority of the people, 85 per cent, go first to Crowley & Milner's basement, to Frank & Seder, to Square Deal Miller, and to these various places.

If they are beginning to have some difficulty with the eye, we find that they take care of glaucoma until it is too late, and today out of 250,000 totally blind in the United States, 30,000 are blind from glaucoma, and 150,000 that we know of, because we have track of them, are being treated in clinics, that are totally blind in one eye and growing blind in the other if it can't be saved. Why? Because of the great economic pressure and advertising in the medical profession.

With myself as an example, I have been brought in for $10.50.

We know what we have heard in this House of Delegates about someone who charged $7.50, as an example, for a box of ointment, was it? We know there are those cases. There are individuals everywhere, in every profession, who will take advantage of the great traditions of their profession. To license a man to practice in medicine is to license a rogue, if the man is a rogue.

Gentlemen, when public pressure comes this way, because the American Medical Association comes out and calls us parasites, and then it is picked up along the line, the pressure becomes tremendous and we fall before the avalanche of that public pressure, to the point that the Wayne County Medical Society did just lately. I want to tell you that those men there feel they are doing the right thing. I know that. But the pressure has been such, going back to this, and going back to the magazines, that even the President of the Society was brought back from his vacation in order that they might pass a resolution saying, sir, that if you prescribe anything from your office —if I am mistaken about it, doctor, you tell me—if you prescribe anything at a profit—that is, if you buy 1,000 of something or other wherever you live in Detroit and give the patient 50 of them—maybe you are not charging anything for that but you know he can't afford to go out and get it in the drug store—that is wrong as against the ethics, and so we have been blown down.

I remember some years ago when Dr. O'Meara used to lead us in some spirited singing around the piano after a meeting of the delegates, and if we were to do that now we should have as our theme song again, "Blow the Man Down." How we have been blown down!

Oh, gentlemen, this does not concern me. It would if we had to go by the Wayne County Medical Society ruling, and I shall abide by the Wayne County Medical Society ruling and I shall help the younger men to get into this in a way that it can be done.

Twenty-seven hundred years before Christ there was an ethical ruling, which became a legal ruling from the standpoint of the state in the Roman Empire, and it said that any man who opens an abscess of the eye with a bronze lens and causes the patient to lose his vision, that man shall have both hands cut off.

Ethics change. Ethics should change, but a short time ago it was unethical for a man to take a salary, let us say, from an industrial concern, and industry needed doctors, but it was unethical.

There is an evolution to law, and there is an evolution to ethics, and when the American Medical Association does not help the Doctor of Medicine in his affairs that have to do with ethics and with law and with economics, but leaves the man as it is doing, we are going to be in a mess. Because the American Medical Association did that, we were beaten carrying the case to the Supreme Court, because they are ethics.

They said that group of doctors down in Washington, or wherever it was, couldn't do that they were going to do. The men said, "Well, we are going to do what we ought to do for the people."

When I went to the American Medical Association headquarters with the outline we had for this House of Delegates, it was read to you and you spent a whole half-day on it, right from this very spot in this hotel. They said to me, "What darned nonsense! Are you a Communist?" I came back and was sustained by this House of Delegates.

I will say for the third time in this House, that when a man from the American Medical Association goes out and says there is nothing to the Sister Kenny treatment, there may be nothing to the Sister Kenny treatment, but when he hasn't sense enough to say, "We do not know as scientific men that there is anything to the Sister Kenny treatment but we will investigate and find out," when they do that, it is time that the House of Delegates of the American Medical Association, from every state, crack down on the American Medical Association and say, "Gentlemen, where is leadership?"

I am appealing to you tonight for the younger ophthalmologists of this state and for one other thing. You have led this country in things that have to do with the economics of medicine and with the science of medicine. The American Medical Association hasn't done it. It has put us in a position where there is the greatest argument from the standpoint of the government. One of the leading educators of this country said to me lately, "The greatest pressure group in the United States for socialized medicine is the American Medical Association and the mouthpiece of the American Medical Association."

Well, gentlemen, I have no fault to find with my county society or with my state society, because you are being blown down.

I see Spalding—did he go out? I saw him a few minutes ago looking at his watch, so I will quit now.

THE VICE SPEAKER: Thank you, Dr. Pino, for your very complete and comprehensive discussion of the implications in the preamble of this resolution before you. He came to a thorough defense of the ophthalmologists, one of the specialties concerned with the implications of the resolution. However, the resolution deals, because of recent publicity, with just one specialty. It would seem he has covered the field well. However, there may be other discussions.

Is there more discussion on the subject?

C. R. GATLEY, M.D. (Oakland): Could I hear the resolution again, as amended?

(Dr. Donald reread the resolution as amended.)

THE VICE SPEAKER: Does that answer your question?

F. J. KEMP, M.D. (Oakland): Yes, but I would like to make a few remarks.

I must admit that I am not the dynamic speaker that Dr. Pino is. I am very inexperienced in public speaking, but it seems to me that much of the criticism that he made was directed toward the sale of medical commodities, whether it be glasses or drugs or medicines, and that he apparently places the disposition of glasses in the same category as that of dispensing drugs or the giving of drugs to patients. I do not consider that giving any patient a few tablets or even dispensing your own medicines is a breach of medical ethics. I think that that is a part of the responsibility of any doctor who has the welfare of his patient at heart.

As a member of this delegation, I really feel humiliated to think that I should be asked to condone the unethical practice of the ophthamologist in accepting rebates from optical companies for merchandising medical commodities. This practice is, in my opinion, medical racketeering, no matter how you may choose to dress it up. If that practice is right, then, gentlemen, it is my humble opinion that it would be perfectly right for any of us to go into collusion with, we will say, ambulance drivers or with the druggists or even with the undertaker, and demand from them a cut of the financial take from any customer which the doctor may choose to send his way.

The faith in the integrity of the Doctors of Medicine, as expressed in the newspapers, magazines and by local Better Business Bureaus, has been shaken on its very foundations, as Dr. Pino has admitted, but this exposure of the Ophthalmological Society in the acceptance of rebates or dispensing medical commodities at a profit for themselves has nullified much of the progress of the Public Relations Committee with this insidious and unfavorable publicity.

I should, therefore, like to move that this original resolution, together with its dressed-up preamble, be stricken from the record in its entirety, as mute evidence that this delegation is unalterably opposed to all that it implies, and I would like, further, to move that the original resolution, as modified and deleted, will likewise be stricken from the record.

THE VICE SPEAKER: There is a motion on the floor. This motion of Dr. Kemp's is not acceptable until the vote has been taken on the motion on the floor. If that is voted down, then Dr. Kemp's motion would be acceptable.

Is there any other discussion on the motion before us?

W. B. HARM, M.D. (Wayne): Mr. Chairman, just to clarify this matter a little, I was on the Committee of Wayne County Medical Society investigating this subject. The Better Business Bureau stated that a rebate on any material used for the care of the patient for profit was unethical. Their secretary stated to me personally that while it seemed—to use the word Dr. Umphrey has applied numerous times—picayune to say that when I gave a dose of penicillin in my office to the man who needed it, I should figure it down to cents and mills, that my price should be approximately the cost of that material. They made the statement that I could charge anything I wanted for service, but in charging for that service, if the patient asked me for an itemized bill, I must itemize my service and itemize the cost of the material used and the charge should be made that way.

I make this statement just to clarify the matter, that the glasses and all other materials used for the care of the patient should be handled in the same manner.

D. C. BLOEMENDAAL, M.D. (Ottawa): I would like to ask one question. It seems to me that since this rebate is out, the cost to the patient is going to be greater than before. If the cost to the patient, say, was $15, that cost is going to be $25 now. I mean just to make the statement. I don't know. I would like to have Dr. Pino give his opinion on this, whether this will increase the cost to the patient or whether it will cut down the cost to the patient.

THE VICE SPEAKER: Dr. Pino, will you answer the question?

R. H. PINO, M.D. (Wayne): Mr. Speaker, I think it is admitted by the Better Business Bureau and by the Wayne County Medical Society, in their consideration of this problem, that the cost to the patient will not be less.

Already the doctors are raising the price of their examination;

that is, some of the people are. They are trying to do it in this way. They are trying to send with their prescription a notice to the company to charge the patient a certain discount, to see if they can't balance it. If that could be carried out completely, it might work, but you see what the newspapers print. The public believes what it reads, and it reads in the newspapers and on the windows and everywhere, "Come to me. Come to the basement store. Come anywhere." They hear it on the radio. "You can get your glasses cheaper," and so on. Consequently they go out to these places.

An examination—I think this is appropos—of 1,000 patients in the City of Cleveland revealed that for that part of the examination that the optometrist gives, which is the refraction only, as compared with the complete examination given by the Doctor of Medicine, the whole package of the eye care, the glasses and examination cost $1.96 more than the same thing does from the ophthalmologist. So the commercial aspect of it makes the cost ultimately more.

You have heard so much about California and what the Better Business Bureau has done for them out there. One of our men went out there, and the other day in Los Angeles he had a pair of these trifocal lenses. They are more expensive. There are three parts. So he went to get some new ones, and the price was exactly the same as he charges in his own office where he does his own dispensing.

Oh, gentlemen, there is no saving to the public, which is what Dr. Don Campbell, Dr. George Frothingham, Dr. J. M. Robb and all these men have contended all along. The only man that stands between the patient and the outside interests is the Doctor of Medicine, for the American Optical Company and some of the others—and I can name them to you, nine different concerns here in Detroit—are striving to get the business there.

It just takes it out of the doctor's hands. That is all. I don't know whether that answers your question.

D. C. Bloemendaal, M.D. (Ottawa): Yes, it does. You see, the cost is higher.

The Vice Speaker: Is there any other discussion?

H. L. Morris, M.D. (Detroit): I have listened with a great deal of interest to Dr. Pino's discussion. I am reminded that Dr. Long years ago, about 1900, stated and proved adequately by photography and clinical histories, that nephroptosis was the cause of a great deal of urinary tract disorders, abdominal disorders, ovarian disorders, and chest disorders, and what have you.

Dr. Pino has given us something to think about. I am not an official spokesman for the Urological Society, but it strikes me, as being an urologist in Michigan, that we as urologists have missed a big opportunity over a period of years, since Dr. Long wrote his book. Less than one per cent of our people that we see with nephroptosis require nephorpexy, according to our present technique and diagnosis. The consequence is that those people are relieved by various kinds of supports and medical and internal treatment of one kind and another.

I think Dr. Pino really has something, because if it is good for the ophthalmologist to get a rake-off on this particular type of appliance that they use on the eyes, I think that Crowley & Milner and the rest of them should have urological departments, where they can make pyelograms and do similar things, and turn over a rebate to us.

They don't do that at Miller's and Crowley & Milner, and Hudson's and other stores, but it is a good idea. I am for it. Over a long period of time I know I have been prescribing these various and sundry supports for the nephroptosis which appears in these people over a long period of time for the relief of their upper urinary tract distress, and I have gotten no rebate. I offer this as a suggestion to the House of Delegates, that this probably is a good idea. If you can get a couple of dollars extra, I for one will subscribe to a urological department in Crowley & Milner's and Hudson's and other department stores, where they can cystoscope them and catheterize the ureters and charge them $3 for the examination and then get a rebate from the store. It is just as logical a conclusion to assume that you are going to get a $3 examination and then get something that you get out of the business.

If the doctor's opinion is worth anything, if it is only worth $3, for God's sake let him be satisfied with $3. If he thinks he can fit a pair of glasses or examine a pair of eyes and it is worth $25, let him charge that $25. If the urologist only evaluates his diagnostic ability at three dollars, let him catheterize the ureters and do the cystoscopy and make the pyelogram and charge $3, and get $10 for the belt he prescribes.

I think Dr. Pino really has something. Mr. Speaker and the House of Delegates: I really am sincere about this. I have been overlooking a bet for a good many years. I am not speaking officially for the Urological Society, but I think the urologists in the house will agree with me that we have been overlooking the rebate from the appliances we apply every day, for which we have not overcharged our patients.

The Vice Speaker: Any other discussion?

T. H. Pauli, M.D. (Oakland): I am of the opinion, gentlemen, that we are talking round and round a circle. We are cutting the issue. We are talking about rebates. Are they right or are they wrong? If they are wrong, let's not pussyfoot. It looks to me as though 100 of us are sitting here pussyfooting. We have a lobbyist who is very well trained, and I don't think he should get your attention away from the fundamental issue: Is we is, or is we ain't?

It is either right or it is wrong. As I understood the refined amendment, we thought it was wrong and we were no longer going to continue, but we did condone.

I don't think that any loophole should be left as to how we stand, and I think that if we approve the proposal, we are condoning it.

I have no objection to a man's charging a just fee. I don't believe anyone has. I don't see why we should in any way, shape, form or manner condone anything that smells of rebate. On the other hand, I do agree that the ophthalmologists are, as a rule, high-minded, and they are ethical. I think it is up to them to clean their own house. I think it is up to us certainly to help them.

I would criticize the AMA if it came out and left them on a limb. It is not particularly a fortunate spot to be on. I don't feel that we can afford to pussyfoot. Pussyfooting probably is not in the dictionary, but I think you all know what I mean. I am very definitely against anything but a frank statement that we are opposed to rebates in all ways, shapes or form or manner, and I am perfectly willing to allow that to have to do with the penicillin charge or what have you.

I don't think the question of rebates has anything to do with the cost of refraction. Indirectly it may have something to do with the quality of medical care. That is not the question. The question is: Is it right, or is it wrong? If you will just keep your mind on those two little words, that is all you need.

R. H. Pino, M.D. (Wayne): Mr. Speaker, the subject of rebates is by the board. That is being taken care of by the Federal Government, and it is being taken care of by many of us who are working on this problem and have been for a long time. We believe we see ways and means of handling it. But whether we do or not, rebates are out, and as I understand the resolution that was brought in, it isn't condoning rebates or anything else.

Here is what I would like to ask the doctor who just spoke. What is—well, I don't care what your specialty is.

T. H. Pauli, M.D. (Oakland): There isn't any.

R. H. Pino, M.D. (Wayne): You have no specialty. All right then, I might ask the question: Are you in general practice?

T. H. Pauli, M.D. (Oakland): That is right.

R. H. Pino, M.D. (Wayne): In Detroit?

T. H. Pauli, M.D. (Oakland): In Pontiac.

R. H. Pino, M.D. (Wayne): Do you prescribe? Do you take care of only patients who are well-to-do?

T. H. Pauli, M.D. (Oakland): Definitely not.

R. H. Pino, M.D. (Wayne): You have them all the way from nothing up?

T. H. Pauli, M.D. (Oakland): That is right.

C. J. Barone, M.D. (Wayne): Point of order, Mr. Speaker. This conversation should be directed to the speaker and not across the floor.

The Vice Speaker: I think you are quite correct. The Chair feels that personalities should not enter into this. Dr. Pino will confine himself to generalities.

R. H. Pino, M.D. (Wayne): Let us say this. The resolution, as I understand it, states merely that it is proper for the ophthalmologist to handle glasses. It makes it possible.

Now what I am thinking is this. Let's take my own office and that of many others. I do take care of people, charging from nothing up to whatever is reasonable. Unlike giving a hypodermic injection from an ampule, I am responsible for an apparatus that one wears on her face, that relieves or does not relieve symptoms. If the patient cannot wear that glass that I prescribe, I am still responsible, to change those glasses as many times as indicated. It is something quite different than simply prescribing glasses.

I understand this resolution is such—Can I do that in my office, or shall I have to give a prescription and send it outside? If I subscribe, let us say, let's bring it back to this. We prescribe, and instead of putting the patient to the bother of going to the drug store for something, and maybe having to pay large prices for it, we have it there handy. We give certain ointments that are hard to get. We may give them away as a part of the package of eye care, or we may charge a little for them. I think that this makes that possible.

Dr. Morris—I don't know whether he was just joking or not. I don't know what it is you prescribe that they might buy somewhere. If you are thinking in terms that you are getting a rebate on what you prescribe, we are getting away with rebates. I have tried to use myself as an example, and the rest of them, but up to the present time we have had no way of handling it. The great optical companies and the Federal Government had no way of handling it. We were almost in between, trying to regulate this thing, and if we would charge everybody a large price and they would go out and pay the large price for glasses, it would certainly be hard on them financially.

I don't believe I quite understood Dr. Morris. I don't know if that explains it.

S. W. Insley, M.D. (Wayne): Mr. Speaker and Fellow Members: I am not so sure that I understand all of the arguments myself.

I might point out that I may be younger than any of the other men in the hall tonight, but after all I have spent exactly twenty years in this House of Delegates, and I have yet to hear in any time in those twenty years a series of arguments that had more circumlocution.

I could say, let's get back to the original motion. I am in favor of it, and I will call for the question.

The Vice Speaker: Are you ready for the question, gentlemen?

H. L. Morris, M.D. (Wayne): What is the question?

The Vice Speaker: Do you want the resolution read again, or the whole preamble?

R. S. Breakey, M.D. (Ingham): Not the preamble.

The Vice Speaker: Just the resolution. Not the whereases.

Douglas Donald, M.D. (Wayne): "Be it therefore resolved:

"*That* It is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"*That* We urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

The Vice Speaker: Thank you. You have heard the resolution.

Are you ready for a vote? All in favor say "aye"; opposed. Will those opposed please raise their hands? Those in favor of it. The motion is carried.

Dr. Donald has one more matter.

XII—h. ACS HOSPITAL STANDARDS

Douglas Donald, M.D. (Wayne): The second resolution presented to this Committee was presented by Dr. Harm yesterday. I will read the resolution.

"WHEREAS, The Michigan State Medical Society feels that it is the governing body in the State of Michigan for its own members;

"WHEREAS, The Michigan State Medical Society through its county and state Ethics Committees has the authority and means of disciplining its members; and

"WHEREAS, The American College of Surgeons through its inspection of hospitals insinuated that some members of the Michigan State Medical Society were guilty of unethical practices without submitting any proof of these deeds; and

"WHEREAS, The American College of Surgeons insisted that hospital superintendents discipline members of their staffs and force their members to sign pledges laid down by the American College of Surgeons for their own members; and

"WHEREAS, The vast majority of the members of the Michigan State Medical Society are not members of the American College of Surgeons and therefore should not be subject to its rules and regulations in any manner; and

"WHEREAS, The American Medical Association has always recognized the county society as the interpreter locally of the Code of Ethics of the American Medical Association; therefore, be it

"RESOLVED, That the Michigan State Medical Society notify the American College of Surgeons that any infractions in ethics by Michigan State Medical Society members with proof of such infractions hereafter be submitted to the Ethics Committee of their county society or of the state society for discipline rather than to superintendents of hospitals, lay or otherwise; and be it further

"RESOLVED, That the Michigan State Medical Society request the American Medical Association to assume the approval of hospitals for the training of interns and residents and that approval of such hospitals and such training be entirely independent of any approval or disapproval by the American College of Surgeons or any other specialized organization."

This resolution came up for discussion and was widely discussed, not only by the Committee but by members of the House of Delegates, who joined in our discussion.

The Committee recommends the rejection of the resolution as worded, although some of the principles contained herein are worthy of further study, and we recommend that this be referred to The Council for further consideration.

Mr. Speaker, I move that the report of the Committee be adopted.

H. W. Wiley, M.D. (Ingham): I second the motion.

The Vice Speaker: You have heard the motion and the support. The recommendation of the Committee is that it be referred to The Council. Is there any discussion?

H. L. Morris, M.D. (Wayne): I would like to ask Dr. Donald to state to the assembly what the statutes of the State of Michigan are relative to this particular matter.

The Vice Speaker: Dr. Donald.

Douglas Donald, M.D. (Wayne): As a matter of fact, Dr. Morris, I will ask you to state that. I don't know what you are speaking of.

H. L. Morris, M.D. (Wayne): Mr. Speaker, quite evidently this motion has to deal with the ruling of the American College of Surgeons relative to splitting the fees, which every physician in recognized hospitals is requested to sign by the superintendent of the hospital, in which he works, pledging his allegiance to the nonsplitting of fees.

There is a statute in the books of the State of Michigan, enacted by our legislative body some twenty-odd years ago, which states very emphatically and specifically that there is to be no division of fees or splitting of fees, which is a thing which I think most of us do not know about.

Now if that is so, and I know that it is because I have read the Act—Can you give me the exact date of that? It was some fifteen or twenty years ago that that legislation was enacted in this state, and very properly. It is on our books of legislation in this state, so that the question which Dr. Harm raises is not a question of the A.C.S. or any other governing body. It is a standing order and rule and legislative action by the legislative body in this state.

J. J. O'Meara, M.D. (Jackson): That was 1915.

H. L. Morris, M.D. (Wayne): Well, 1919. I will admit a couple of years difference.

W. B. Harm, M.D. (Wayne): Both in the Committee and as you heard here tonight, the way it was expressed was that it was my resolution. It seems to be brought out that this is a personal grievance of mine.

There is a principle here. Dr. Morris has made the statement that I am objecting to a ruling on the splitting of fees. There is nothing in this resolution that says anything about splitting of fees, and if he is a wizard as a lawyer, I would like to have him define what is splitting of fees.

This question came up when the examiner of the American College of Surgeons entered several of our hospitals. In going through the hospitals, he noted that two men were at the operating table. In some cases it was a general practitioner assisting a surgeon. In another case, in one particular hospital, it was a young man with three years of residence training in surgery, who was doing an operation that he had not done too many times, and he asked one of the senior surgeons to step in and stand by while he was doing it, which I think was very creditable of the young man to do.

Two men being at the operating table, the inspector inferred that the case was being split, and without making any more inquiries, he accused the staff, the entire staff, of various hospitals of being unethical.

It is not unethical to share a case. I think you will all admit that. The unethical part of it seems to be the splitting of fees. I don't know the answer to that.

However, the American College of Surgeons took it upon themselves to reprimand the whole staff of these hospitals through the hospital superintendent, without ever supplying proof that these men had done anything unethical, and they managed to do it because of the fact of their control over hospitals through the approval of residents. Remember that when they withdraw their approval on residencies, they do not withdraw the approval of the residencies for surgery; they withdraw the approval for pediatrics, for urology, Dr. Morris, for radiology. They withdraw all residents approvals.

The hospital superintendents go by the bible as written by the American College of Surgeons, called the Manual.

The thing that one of the staffs in this city was asked to sign was not the pledge. We have all signed that pledge. It is part of your hospital application. But they set on it the bottom half of one of the pages in the American College of Surgeons' Manual, in which there is no pledge. There is nothing said about it, that you must do it or you will do it. All it is is a statement of what should happen. It includes that a separate bill should be sent out; that the general practitioner should not assume a place at the operating table, which in my opinion is the result they were after on this case to exclude the general man and the nonspecialized surgeon from the operating room, that he shouldn't be there at the table because of the fact that that place at the table belongs to the first resident and there is another place for the second, and then the third. I don't know how you number them. I said to the Committee last night, "Somebody better grab it whether he is first, second or third."

Through that method they have obtained control over the whole hospital staff, not only their own surgeons but the general men, the internists, the urologist, the radiologist, the o.b. men.

They put out this Manual, and the Manual is divided on what each department should have. One pathologist the other day said the inspector walked into his pathological laboratory and told him he had to many books there, that he shouldn't have books in his laboratory; they should be down in the library. That is just one of the little things that happen.

It is my opinion that the American College of Surgeons has no right to ask the nonmembers of their organization to sign anything for them. I will willingly abide by the rules laid down by my hospital. I will abide by the rules laid down by the county medical society, the state medical society or the American Medical Association, because they represent a group who are all doctors, not only some. We should be controlled by our main group. There is no reason for the American College of Surgeons to step in and tell all of us what to do. They did not attempt in this case to go out and reprimand their own members who are members of the hospital staff. That would be starting out with their own members and bringing them into the light. They didn't dare do that. So they picked on everybody. Then their members didn't shine, but if there was any unethical practice, in order to have it occur under the circumstances, their own members were guilty just as well as anybody else. But they did not attempt to put the reprimand on their own members but included everybody in the hospital, and they included them from the top, from our consulting and retired staff on down to the courtesy staff.

In the Committee room mention was made that this had happened in Detroit. There is still a principle behind it. Under the Hill-Burton Act, you are going to have hospitals all over this state. You are going to have them regulated, and you fellows out in the states are going to be up against the same thing we are here, and the same thing can happen to you, if the continuation of such occurrences is going to disrupt the medical profession. It is a peculiar thing that these occurrences, particularly in Detroit, happened in hospitals with general practice sections. I make no accusation there, but it did occur.

Now, gentlemen, it is my feeling that I am willing to submit to any rules and regulations for organized medicine, but if I have to obey, in addition, the rules of each specific group, the American College of Surgeons, next week the American College of Physicians may make out rules, and the pathologists may, the radiologists may, and maybe the general practitioners will, and you are going to have

so many rules and regulations nobody can follow them, and no one can abide by them.

The second part of this resolution has already been approved by your House of Delegates of the American Medical Association, and they are already preparing to take over the approval of hospitals, the approval of training for internships and the approval of training for residencies. They have already done it to a great extent in their Boards. These same hospitals that the College of Surgeons is taking away the privileges and residencies, are still recognized for residencies by Boards.

But, gentlemen, if I have to abide by the rules and regulations of all these higher bureaucrats of our profession, then it is my sincere believe that I am ready to go for federalized medicine, where we will have laws and rules and regulations that are jammed down our throats by politicians, but at least we will have only one set to follow. Thank you. (Applause)

L. W. Gerstner, M.D. (Kalamazoo): Mr. Speaker, certainly now is the time for the men around the state to assert themselves. I know many of us are in sympathy with the view that has just been stated.

Secondly, certainly putting this in the lap of The Council will not settle it. It should be settled by the men in the state who are represented here.

I hope that the motion to have this placed in the hands of The Council will not pass. I further hope that the recommendation of the Committee will not pass. I think that this is something that we should very carefully consider and discuss by members throughout the state.

H. H. Riecker, M.D. (Washtenaw): Mr. Speaker and Members: I move an amendment to Dr. Donald's Committee report, deleting the words "and be referred to The Council for decision."

Thank you.

The Vice Speaker: Before I ask for a second to that, may I just read the last line of this?

"The Committee recommends the rejection of the resolution as worded, although some of the principles contained herein are worthy of further study, and we recommend that this be referred to The Council for further consideration."

I understand Dr. Riecker's amendment is to omit reference to The Council. Is that correct?

H. H. Riecker, M.D. (Washtenaw): That is correct. I didn't have the exact wording.

R. A. Springer, M.D. (St. Joseph): I second the amendment.

The Vice Speaker: The amendment is seconded.

C. J. Barone, M.D. (Wayne): I am like many others in this audience in regard to being a poor speaker. I want you to consider the fact that many places in the City of Detroit, in Wayne County, in the State of Michigan, the general practitioner is not allowed to go into hospitals—not all hospitals but a great many of them have that ruling.

The American College of Surgeons, about a year or two years ago stated in its booklet that the governing board of each hospital shall determine the rules and regulations that shall be carried out for that hospital. Now we find that the American College of Surgeons is entering the various hospitals in this state and frowning upon those hospitals that have general practice sections.

It is my firm belief that if the practice of medicine, as we know it, is to survive we have a great deal of need for general practitioners, more than we have for specialists. The specialists cannot survive, nor can they keep their hospitals full of patients unless the general practitioner refers the patients to them.

One other point. I know many internists. I know many specialists, board members, College of Surgeons, or what have you, who when it comes to making a night call refuse to make it. They expect the general practitioner to go out, give the patient a quarter of a grain of morphine or whatever you want, and immediately refer the patient then, who probably needs hospital care, and take him immediately to the admitting clerk and say to this patient, "I want to thank you for allowing me to take care of you at the time of your need, but now you are in a specialists' hospital where the Lord knows what will hapnen to you. But if you get out alive, come back to me, and I will take care of you, either in my office or in your home."

Another point I would like to make is simply this, that in order to become a member of the American College of Surgeons in some instances all you have to do is know the members of the American College of Surgeons in your neighborhood who are friends of yours and write up about 100 histories, or whatever the number is, present them, and you will be accepted.

Gentlemen, if that is not happening today, I can take you back to three or four years ago, and I could state the name of a man who was accepted under those circumstances. He did not have 80 or 85 per cent surgical cases in his practice, nor did he have 80 or 85 per cent surgical cases in the hospital that he did his major work in. He had a grand sum of 35 per cent of surgical cases, and the rest of them were equally divided among the other specialties.

Now I was told when I brought this to the attention of a noted member of the American College, that under those circumstances he wouldn't have got his F.A.C.S., and I asked him if somebody lied in regard to the matter.

Gentlemen, I do not think that this matter that is before this body today should be left in the air. I think we should have backbone enough in this House of Delegates to either pass that or turn it down. I thank you.

The Vice Speaker: Any further discussion?

R. W. Teed, M.D. (Washtenaw): Mr. Speaker—

The Vice Speaker: We have a motion, gentlemen, and a motion to amend. Will you try to confine your main discussion of the moment to the question of the amendment, which pertains to referring the question to The Council? I don't want to cut off discussion on the whole subject, but try to take things in order, gentlemen.

R. W. Teed, M.D. (Washtenaw): Mr. Chairman and Gentlemen of the House: I would like to say, first, that I am a member of the American College of Surgeons. Twelve years ago, when I joined the organization, there was agreement that I would pay $500 over a period of twenty years, and that would constitute the financial part of the fellowship. Last January I got a statement to the effect that the dues for the fellowship were now $1000 and I should pay up.

I submit, gentlemen, that an organization which has no more morality regarding its own agreement has very little right to talk to another man regarding morality in his practice, particularly when, as Dr. Harm says, it has not been proven.

I, therefore, suggest, or submit that this amendment be turned down and that the House pass action on this question.

T. P. Wickliffe, M.D. (Houghton): I am not from Wayne County. I am from the Upper Peninsula. I am a general practitioner and have practiced for thirty years. I do general surgery. I do obstetrics, gynecology and pediatrics. I practice in a small hospital.

I still think we should have some governing board to govern the practice of some doctors. I have a young son who has finished one year in medicine, starting on his second year, and I hope that if I am not alive, that somebody will be around to direct him in the right channels to practice good, ethical medicine.

Notwithstanding the fact that I am not a member of the College of Surgeons—and I would like to be if I could qualify—I am sorry to hear this gentleman who preceded me talk the way he did. If I had accepted membership in the American College of Surgeons, I would not say what he said. I still think that somebody has got to regulate a great many of us doctors. In my own small town, in my own small county, we need a hell of a lot of regulations. Thank you. (Applause)

The Vice Speaker: Any other discussion?

William Bromme, M.D. (Wayne): My few remarks are not about the matter at hand, but simply to make an explanation about the fees. I became a member of the College of Surgeons in 1939, and I was told at that time that life membership dues were a certain sum. In January of 1940 I received a note, announcing that by virtue of an action by the Board of Governors, the life membership fee would be doubled by a given date, but if my life membership was paid in full by 1949, my life membership fee would be thus and so.

I think that is what the speaker was referring to. If one paid up his life membership dues at a given time, he would not be subject to the increase in dues. That is certainly true in the figures I got.

The Vice Speaker: Any other discussion?

H. H. Riecker, M.D. (Washtenaw): Will you clarify my motion?

The Vice Speaker: I understand your motion, Dr. Riecker, it is to omit the portion of the recommendation from the Reference Committee which would refer this matter to The Council for consideration and recommendation.

(Calls for the question.)

Are you ready for a vote on the amendment, not to refer this? All in favor of not referring this to The Council, please say "aye"; all those opposed, in other words, to refer it to The Council. Those in favor of not referring, please raise their hands. The Chair rules that the motion not to refer was carried, so the motion as amended is before us. Will you read that, Dr. Donald, as it would be amended?

Douglas Donald, M.D. (Wayne): The motion as amended would read as follows:

"The Committee recommends the rejection of the resolution as worded, although some of the principles contained herein are worthy of further study."

The Vice Speaker: That would be the motion then, because the amendment has stricken out the last portion. Are you ready to vote on that motion?

W. W. Babcock, M.D. (Wayne): Gentlemen, I am sorry to prolong this further, but I feel I must point out what I think is right and what I think is wrong.

In the first place, I am a member of the American College of Surgeons, and I wish to substantiate what Dr. Bromme stated to you. We were allowed to pay up our $500 fee if it had not been paid, without having to pay the excess, if we did it within a certain amount of time. I personally felt no resentment at that.

When I learned my surgery I learned that under the preceptor method, and gentlemen, I tried not to, but I know I buried some of my mistakes.

I cannot help but feel, having learned by the preceptor method—and I feel that I had a good preceptor—that the training of surgeons by the residency rule is preferable, that we are putting out better surgeons, and I cannot help but feel that the American College of Surgeons has contributed tremendously to the advancement of surgical care and practice. I sincerely feel that, though I myself was never a surgical resident.

That being the case, if we disfranchise the American College of Surgeons from the control of surgery in our hospitals, I can't help but feel that we will be taking a step backward. We are referring the control of surgery to the AMA, and they will have to learn, and it will take many, many years before a smooth-running organization as we now have could control the proper type of surgery in our hospitals.

I do sincerely feel that Dr. Harm has some valid objections. I cannot blame any man, particularly one who is not a surgeon, for resenting the fact that he must sign when he attends a staff meeting. We are being regimented. I can't blame Dr. Harm for resenting the fact, because I know he is a busy man, that he is called on at many hours, that without a valid excuse he will be expelled from the staff if he does not attend three-quarters of the staff meetings, but that is a point that is beside the point when it comes to the control of surgery as practiced in our larger hospitals.

The Vice Speaker: Any other discussion?

B. T. Montgomery, M.D. (Chippewa-Mackinac): I am not a member of the American College of Surgeons. I am a general practitioner, but I think what we need in medicine is more honesty among the general practitioners and among the surgeons.

I think that the general practitioner doesn't get probably his fair share. This splitting of fees is difficult. The case is worked up, main diagnosis made, and turned in to the hospital, to the surgeon for operation. I have had special training in surgery, and I was a resident surgeon, but when I went to Sault I found that in order to make a living I had to do general practice, and that is what I am doing. So I have the general practitioner's viewpoint when it comes to making a living, but I also think that we ought to raise our standards in all of our hospitals on the level of diagnosis. We should operate for a definite reason, rather than for the one hundred bucks the patient may have in his pocket. In order to keep surgery on that level, we have to have some control, because we are all human and humans were born to err, especially when it comes to money.

I think that we should still have the American College of Surgeons or some like body to attempt to keep what I call carpenter surgeons from operating unnecessarily. I know of plenty of operations that are done for patients, displaced uterus, and we call that the passion operation in our hospital, and I know plenty of patients that go to the operating room that have a so-called chronic appendix removed and sometimes they drag the operating room team out at midnight because they don't know when they will be able to work the operation in otherwise, so they make it an emergency.

Personally, I think we should get back and get a little bit more religion into our lives when we are practicing medicine.

H. H. Riecker, M.D. (Washtenaw): Will the Chair state the motion?

The Vice Speaker: The Reference Committee moves, and Dr. Donald read it. Do you want it read again?

(Calls for the question).

Are you ready for the vote?

W. B. Harm, M.D. (Wayne): May I have the question?

The Vice Speaker: Just a moment. There is a question on the floor. I will try to answer it. You have heard the resolution read. You heard the report from the Reference Committee, and then the motion from the Reference Committee. That is what you are voting on. This motion reads as follows:

"The Committee recommends the rejection of the resolution as worded although some of the principles contained herein are worthy of further study."

That is the motion on which you are voting now, the motion as amended.

W. B. Harm, M.D. (Wayne): May I ask a question?

The Vice Speaker: Yes.

W. B. Harm, M.D. (Wayne): If this motion is turned down, will there then be a vote on the original resolution?

The Vice Speaker: If the motion is turned down, the resolution is before the House for disposition, the original resolution.

All in favor of this motion of the Reference Committee say "aye"; opposed.

H. L. Morris, M.D. (Wayne): What is the original, Mr. Speaker?

The Vice Speaker: This is the motion. There is no original motion. There is only one motion before the House. The resolution that Dr. Harm presented was referred to the Committee.

W. B. Harm, M.D. (Wayne): Dr. Harm just asked the question.

The Vice Speaker: It is a motion to reject. Will you please stand? Those who are in favor of rejecting the resolution.

W. B. Harm, M.D. (Wayne): Is that rejecting the resolution or favoring the Committee's report?

The Vice Speaker: The motion is to reject the original resolution. That is the motion of the Reference Committee. That is what you are voting on.

Will you gentlemen be seated, and those who are opposed to the motion which would reject the resolution stand. Do you understand what you are voting on?

Delegates: No.

W. B. Harm, M.D. (Wayne): Not the way you are stating it.

The Vice Speaker: Those who are voting in opposition to this motion from the Reference Committee now would be tantamount to wishing to vote on the original resolution. Is that clear?

Do you know what you are voting on?

Delegates: No.

The Vice Speaker: I will state it again. Dr. Harm brought in a resolution to this House, which was referred by the Speaker to the Reference Committee. The Reference Committee came back to you with a refusal of the resolution, recommending that it be not accepted. Part of their motion was deleted. We have taken one vote on this refusal. Now I ask for the negative vote, which denies their refusal or gives us an opportunity to vote again or reconsider the resolution presented by Dr. Harm.

W. B. Harm, M.D. (Wayne): Mr. Chairman, I rise to a point of order. I think the Chair has balled up the entire voting on this motion. He should put it either to accept the recommendation of the Committee or not to accept it. For that reason I ask for a re-vote.

The Vice Speaker: All right, Dr. Harm, I will accept that suggestion. I will ask for the affirmative vote accepting the recommendation of the Committee. Those in favor of accepting the recommendation of the Committee please stand.

S. L. Loupee, M.D. (Cass): Mr. Chairman, are those recommendations amended?

The Vice Speaker: Yes, they have been amended.

S. L. Loupee, M.D. (Cass): The motion carries the amendment. That has been passed. What we are voting on is amended. Then if you approve it, the whole thing dies.

The Vice Speaker: Right. Will you be seated, and those wishing to reject the Committee's report please stand? The motion supporting the Committee's recommendation is carried.

Dr. Donald, do you have anything else?

Douglas Donald, M.D. (Wayne): Nothing more to bring before the House.

Mr. Speaker, I move the acceptance of the whole report of the Committee on Ethics.

(The motion was seconded.)

The Vice Speaker: It is moved and seconded to accept the report of the Committee on Ethics. Any discussion? If not, all in favor say "aye"; opposed. Carried.

Now we still have some business, a supplementary report from The Council. Dr. Beck!

XII—b. ON REPORTS OF THE COUNCIL

O. O. Beck, M.D.: Mr. Speaker and Delegates: This pertains to a motion adopted by The Council at special session this afternoon, and it is referred to the House of Delegates.

First, that the Seventeenth and Eighteenth Councilor Districts be added from Wayne County, the term of the Councilor from the Seventeenth District to expire in 1949 and the term of the Councilor from the Eighteenth District to expire in 1953.

Second, inasmuch as we do not have sufficient data on boundary lines at the present time or mechanism for nominating by districts in Wayne County, The Council recommends that nominations for the two new Councilors be made by the Wayne County Delegation and that Wayne County be authorized to make boundary divisions and report to The Council prior to the next meeting of the House of Delegates.

The Vice Speaker: You have heard the motion that Dr. Beck has presented from The Council. Is there a second?

R. S. Breakey, M.D. (Ingham): I move the adoption of The Council's supplementary report.

The Vice Speaker: We have a motion from Dr. Breakey for the adoption of The Council's supplementary report. Is there a second?

E. G. Krieg, M.D. (Wayne): I second it.

The Vice Speaker: Any discussion?

If not, all in favor say "aye"; opposed. It is carried.

Are there any further reports from any Reference Committees?

C. L. Weston, M.D. (Shiawassee): I have a brief report from the Reference Committee on Reports of The Council.

Mr. Speaker and Delegates of the House: You will recall that in the previous report of the Reference Committee on Reports of The Council a question was raised by the Committee, asking if The Council could explain to us why the interest on eighty-four thousand dollars worth of bonds for a year amounted to only $346. The Committee would like at this time, if Dr. Brunk is present, to have him give lucid explanation, which I think he can do easily. Is Dr. Brunk here?

The Vice Speaker: Dr. Brunk will attempt to answer the question now.

A. S. Brunk, M.D. (Wayne): Gentlemen, I don't think it would be very hard to answer why we have such a small return on our bonds. Inasmuch as the market has been rather unstable lately, we have confined our investments entirely to government bonds, and of course you know what the rate of interest is that the Government pays. Now your return is simply what the Government pays on Government bonds. The income as it accumulates and gets to be a sizable amount is reinvested and consequently we have very little balance on hand.

C. L. Weston, M.D. (Shiawassee): I would say that as far as the Committee is concerned, that answers the question.

If there is no further discussion, that closes the report of the Committee. Thank you, Doctor.

The Vice Speaker: Any other Reference Committees who have a supplemental report?

If not, I would like to turn the chair back to the Speaker.

(J. S. DeTar, M.D., the Speaker, resumed the chair.)

The Speaker: We have only a few items left on the agenda.

I would like to ask the Committee on Credentials—Dr. O'Meara, Dr. Bailey and Dr. Harm—to escort all present ex-Presidents of the Society to the platform.

J. J. O'Meara, M.D. (Jackson): May I have Dr. Gruber in Dr. Bailey's place?

The Speaker: I think the exchange is probably in our favor. Will you please escort the ex-Presidents—Dr. A. S. Brunk, Dr. R. S. Morrish, Dr. Grover C. Penberthy, Dr. Henry A. Luce, Dr. Claude R. Keyport, Dr. L. J. Hirschman and Dr. Henry Cook to the platform?

There are plenty of chairs. Some of our ex-Presidents have grown heavier, but they are good chairs. So step right up, gentlemen. We would like to see what our ex-Presidents look like.

(The audience rose and applauded as the Past Presidents were escorted to the platform.)

The Speaker: You have seen the working force on the platform all this time. Now here is the glamour. Welcome, gentlemen. We are glad to see you.

The Speaker: I would like to ask the Committee on Credentials to bring President P. L. Ledwidge and President-Elect E. F. Sladek to the platform.

(The audience rose and applauded as Dr. Ledwidge and Dr. Sladek were escorted to the platform.)

The Speaker: Here are your President and President-Elect. Welcome, gentlemen.

Don't go away, gentlemen. We are going to elect a few more.

I would like to ask Dr. Spalding, who is Chairman of the Reference Committee of Constitution and By-laws, to explain to us, before we proceed with the election of Councilors, what the Constitution

specifies concerning the election of the two new Councilors for the two new Councilor Districts. Dr. Spalding.

E. D. Spalding, M.D. (Wayne): Gentlemen, after your forbearance this morning, I hoped I was going to get out of here permanently, but I promise that what I have to say will be very brief. It comes out of the fact that this House of Delegates today has granted Wayne's petition for two new Councilors by subdividing Wayne four ways, meaning two new Councilorships. There are four points.

In the first place, the basis on which this authority rests is as follows: If any of you have your mimeographed Constitution lying around, if you will turn to page 7, Chapter 8 of the By-laws and Section 3, under the heading of the House of Delegates, Section 3 of Chapter 8 specifically states that the House of Delegates, among other things, shall provide for the organization of Councilor Districts.

Secondly, on page 11, under Chapter 11, Section 1, the question of the terms of the Councilorships and their expiration dates—under Chapter 11, Section 1, among officers it says that the officers of the Society shall serve until the next Annual Session, provided that Councilors shall serve for five years, and provided, further, that not more than four Councilors' terms shall expire normally at any one annual session.

Obviously, to permit this to become effective, it is necessary to set up the rotation of your Councilorships, so that they will expire at certain times.

The third point is on page 8, Chapter 8, Section 10, subsection (g), under the House of Delegates, about the election of Councilors. Section 10 (g) says that the House of Delegates "shall elect the Councilors upon the nomination of the Delegates of the Councilor District whose Councilor's term expires."

Obviously, with the new Councilor Districts created, there is no term expiring, but a new term is being created, which is essentially the same thing.

Now, finally, in case there is any doubt in anybody's mind as to whether this is a proper thing that is being suggested, I would refer you to page 7, Section 10 of Chapter 8, under the House of Delegates, where it specifically says that "The House of Delegates is the legislative body of This State Society, and shall have authority to adopt and institute such methods and measures as it may deem most sufficient for the upbuilding and establishing of the interest of the profession in Michigan.

It is highly important for the interests of the profession in Michigan as a whole, and in Wayne County in particular, that these new Councilorships shall come in the general rotation already established.

On page 25 of your Handbook you have at the foot of the page the names of all of your Councilors and the dates of expiration, and you will note that in 1949 there is only one Councilorship that is terminated. All the rest have three or four terminations. Wayne, in its two present Councilors, has one that terminates in 1950 and in 1951. It is important that in the creation of these two new Districts we arrange that the Council shall have another Councilor whose term shall expire in this year, when only one Councilor is now to be lost, and another Councilor District coming over to the year 1953.

IX—s. MOTION SETTING TERMS OF COUNCILORS OF 17th & 18th DISTRICTS

In order to create this proper rotation of new Councilorships voted by the House of Delegates this afternoon, I move that the terms of rotation of the new Councilorships be so set that they will terminate for the new District No. 17 to terminate in the year 1953, and the new District No. 18 to terminate in the year 1949, which only has one Councilorship terminating in that year.

I so move.

The Speaker: Is that motion seconded?

F. A. Weiser, M.D. (Wayne): I second it.

The Speaker: You have heard the motion, and it has been supported. Is there any discussion?

If not, all in favor signify by saying "aye"; opposed "no." The motion is passed.

XIII—Election of Officers

The next order of business is the election of a Councilor from the Eleventh District, the incumbent of which is R. H. Holmes, M.D., of Muskegon.

Before I declare the floor open for nominations, I should like to appoint as tellers Dr. Breakey of Ingham as Chairman, Dr. Springer from St. Joseph, Dr. Teed of Washtenaw, Dr. Wickcliffe of Houghton, Dr. Ho of Clinton and Dr. M. H. Miller of Wayne. Will the tellers meet Dr. Breakey in the back of the house and decide how to get through with this?

XIII—a. COUNCILOR—11th DISTRICT

The Chair declares the nominations are open for Councilor of the Eleventh District.

T. J. Kane, M.D. (Muskegon): I wish to nominate Dr. Charlie Paukstis of Ludington for the Eleventh District Councilor.

The Speaker: Dr. Charles Paukstis has been nominated for the position of Councilor of the Eleventh District. Are there other nominations?

Nominations should be made by delegates from that district.

R. D. Risk, M.D. (Muskegon): I move that the nominations be closed.

The Speaker: It is moved that the nominations be closed. Is that motion supported?

E. G. Krieg, M.D. (Wayne): I support it.

The Speaker: Is there any discussion?

If not, all in favor say "aye"; opposed, "no." The motion is passed and Dr. Charles Paukstis is automatically elected by a viva voce vote of the House.

The Constitution provides that we must vote by ballot unless there is only one nominee for the position.

XIII—b. COUNCILOR—12th DISTRICT

The next order of business is the election of a Councilor from the Twelfth District, Dr. A. H. Miller of Gladstone, incumbent.

W. A. LeMire, M.D. (Delta-Schoolcraft): I would like to nominate Dr. A. H. Miller of Gladstone as Councilor of the Twelfth District.

The Speaker: Dr. A. H. Miller has been nominated to succeed himself.

B. T. Montgomery, M.D. (Chippewa-Mackinac): I second the nomination.

The Speaker: Are there any other nominations?

B. T. Montgomery, M.D. (Chippewa-Mackinac): I move that the nominations be closed.

(The motion was seconded.)

The Speaker: The motion has been seconded. Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed and Dr. A. H. Miller has been elected to the Councilorship to succeed himself in the Twelfth District.

XIII—e. COUNCILOR—13th DISTRICT

The floor is now open for nominations for the Councilorship of the Thirteenth District, W. H. Huron, incumbent.

D. R. Smith, M.D. (Dickinson-Iron): Mr. Speaker, I wish to nominate Dr. W. S. Jones of Menominee County for the Thirteenth District.

T. P. Wickliffe, M.D. (Houghton): I second the nomination.

The Speaker: Dr. W. S. Jones has been placed in nomination for this position. Are there any further nominations?

T. P. Wickliffe, M.D. (Houghton): I move the nominations be closed.

H. L. Morris, M.D. (Wayne): I second the motion.

The Speaker: It is moved and seconded that nominations be closed. Is there any discussion? If not, those in favor say "aye"; opposed, "no." The motion is passed and Dr. Jones is elected to this Councilorship.

XIII—d. COUNCILOR—17th DISTRICT

Nominations are now open for the Councilorship of the Seventeenth District, the new Wayne District, with term ending in 1953. Nominations are now open.

C. K. Hasley, M.D. (Wayne): I should like to propose the name of an ex-president of Wayne County, and when I state the name, you will all realize that he has done a whole lot for the General Practice group, nationally and locally. I would like to nominate W. B. Harm as Councilor of the Seventeenth District.

H. L. Morris, M.D. (Wayne): I move the nominations be closed.

C. I. Owen, M.D. (Wayne): I second the motion.

The Speaker: The motion that the nominations be closed has been seconded. Is there any discussion? All in favor say "aye"; opposed, "no." The motion is passed.

XIII—e. COUNCILOR—18th DISTRICT

The Speaker: The next order of business is the selection of a Councilor for the Eighteenth District, of Detroit, with the term to end in 1949, a one-year term.

D. C. Beaver, M.D. (Wayne): I would like to nominate Dr. William Bromme to represent Wayne in the Eighteenth District. You will recall that Dr. Bromme was the Chairman of the Reference Committee on Resolutions and you have heard him several times in the last few days.

The Speaker: The name of Dr. Bromme has been placed in nomination for Councilor of the Eighteenth District. Are there other nominations?

J. J. Lightbody, M.D. (Wayne): I move that the nominations be closed.

E. G. Krieg, M.D. (Wayne): I second the motion.

The Speaker: Is there any discussion? If not, those in favor say "aye"; opposed, "no." The motion is passed and Dr. Bromme is elected Councilor of the Eighteenth District.

XIII—f. DELEGATES TO AMA

The next order of business is the election of Delegates to the American Medical Association. If you will consult page 11 of your Handbook, you will discover that Dr. Barrett, Dr. Gruber and Dr. Keyport are the incumbents in that position. The floor is now open for nominations.

W. B. Mitchell, M.D. (Kent): Mr. Speaker and Members of the House of Delegates: I would like to place in nomination the name of Dr. C. R. Keyport of Grayling to succeed himself as Delegate to the American Medical Association.

The Speaker: The name of Dr. Keyport has been proposed.

E. D. Spalding, M.D. (Wayne): Mr. Speaker, it is a great pleasure to place in nomination the name of Dr. W. D. Barrett to succeed himself.

The Speaker: Dr. Barrett has been nominated.

W. S. Jones, M.D. (Menominee): Mr. Speaker, I would like to place in nomination the Councilor from Thirteenth District, W. H. Huron. Dr. Huron has been at Iron Mountain twenty-two years. He has been president and the secretary of the society. He has served you well for ten years as a Councilor.

I think that if you go back in history, the Upper Peninsula has had one delegate to the American Medical Association in thirty years. At the present time we need men who can represent the State of Michigan in the American Medical Association, who are friendly, who are young enough to have a lot of fight and who get along, who are old enough to be mature. Dr. Huron recently, as Councilor, went down to Washington, and I have been told that he made a very, very favorable impression on our Congressmen and our two Senators.

Dr. Huron is a man who gets along with everybody, and I am sure that those who know him will believe he will make a very fine delegate to the American Medical Association.

THE SPEAKER: The name of W. H. Huron has been proposed. Are there other nominations?

DOUGLAS DONALD, M.D. (Wayne): Mr. Speaker and Members of the House of Delegates: I wish to put in nomination the name of Dr. T. K. Gruber from Wayne.

THE SPEAKER: The name of Dr. Gruber has been proposed. Are there other nominations to come from the floor of the House?

W. B. HARM, M.D. (Wayne): I move the nominations be closed.

THE SPEAKER: Is that motion seconded?

F. G. BUESSER, M.D. (Wayne): I support it.

THE SPEAKER: Dr. Buesser of Wayne supports the motion. The Chair will ask, in all fairness, are there any other nominations? If not, the Chair will put the motion. All in favor say "aye"; opposed, "no." The motion is passed and we will proceed to the balloting. According to the Constitution, we will vote from the slate, and those candidates which receive the three highest number of votes will be elected, and the order of seniority will be determined by the number of votes.

In case you cannot read that far, Dr. Keyport, Dr. Barrett, Dr. Huron and Dr. Gruber are the nominees from which to choose three. Put three names on your ballot.

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, the point has been raised, and I think it should be announced from the Chair. Four names will invalidate a ballot, but less than three will not. Is that correct?

THE SPEAKER: That is right. If you wish to vote for only one or two, you may. If you put four names on the ballot the ballot will be thrown out. We are voting for three. You may vote for any number up to three.

(The votes were cast.)

XIV—Remarks re National Physicians Committee by Counselor C. E. Umphrey, Detroit

THE SPEAKER: While the tellers are working, I am going to ask Dr. Umphrey to take the microphone for a few minutes. He asked for the privilege of the floor, and if there is no objection, I will turn the floor over to Dr. C. E. Umphrey, Councilor of Detroit.

C. E. UMPHREY, M.D. (Wayne): Thank you, Mr. Speaker. I did ask for the privilege of the floor, but many of our members have left.

A number of questions have been raised about the National Physicians' Committee. I had hoped at this time to make some remarks about it. However, I have a lot of material and that material will be at one of the booths downstairs in the reception booth, and you can review it there, and if you have any questions, I hope you will ask them.

This load of information to the doctors is getting just a little bit heavy, and I want all of you who are here to know the facts about the National Physicians' Committee.

With those few words, instead of giving you the story I wanted to give you tonight, if you want information you know where it can be found. If you have questions to ask, we shall try to answer them satisfactorily. If they cannot be answered satisfactorily, I can resign as—not your State Chairman as the official of this body, because there has been nothing official between the State Society and the National Physicians' Committee.

THE SPEAKER: Thank you, Dr. Umphrey.

Dr. Foster, our Secretary, has an announcement or two he would like to make.

Thank you for being so patient, gentlemen. This is important business and we won't be very long.

(Announcements by Secretary Foster.)

THE SPEAKER: I thought it would be very fine if we could have a word, although they have no status now, from our ex-Presidents. We would like to hear from Henry Cook, who was President of the Society back in 1937.

HENRY COOK, M.D.: All I have to say is this, that I am very happy to be here and listen to your deliberations. I sort of stayed away from the state meetings for the last two or three years since I was a delegate, because I might feel that I am one of the enlisted men, as it is a very great pleasure not to have to carry the load and the responsibilities of the state organization.

I will say that you have advanced very far since I was Chairman of The Council and also the President of the Society.

I would just like to state that during the time when I was Chairman of The Council Dr. Penberthy was President, and Bill Burns was employed. It might interest you to know of our conference with Mr. Burns when he was employed. I don't know whether Mr. Burns is here, but we went down to meet him in the Wayne County Medical Building. We said to Bill, "You have been selected to be the Executive Secretary of the Michigan State Medical Society. About what do you think you ought to get?"

Bill said,—I don't know the amount.

We said, "That is done."

Then Bill said, "What do you expect me to do?"

We said, "Well, if we didn't think you knew what you ought to do, we would not have employed you. So just go ahead and do your job."

Grover said, "What time does the ball game start?" and we went to the ball game.

I would like also to take credit myself, personally, for recommending Dr. Foster as the Chairman of the Public Relations Committee, the first Public Relations Committee which the Michigan State Medical Society had. Due to the good work that he did in the organization of the work of the Public Relations Committee, he advanced to the position he now holds.

That might be of interest to you. Those facts are all true. I am very happy, as I say, to be with you.

THE SPEAKER: Thank you, Dr. Cook.

It is a pleasure to see one other living and fairly well moving ex-President here, and here he is—Dr. Penberthy.

G. C. PENBERTHY, M.D.: Mr. Speaker, Gentlemen and Friends: I am sorry that I missed this evening's session, but I just brought Dr. Frank H. Lahey of Boston, one of our guest speakers, in from Willow Run, and I hope the proceedings were friendly and that all went well. I don't know what went on during the discussion of certain Reference Committee activities, but I will be interested to learn about them. I don't know who has been elected. It is very interesting.

As a member of the Wayne County Medical Society, I extend my greetings to the men from out in the state. We are happy always to have the State Society as our guest. Thank you.

THE SPEAKER: Thank you very much.

Dr. Breakey, will you step to the microphone and announce the results of the election?

R. S. BREAKEY, M.D. (Ingham): The three elected delegates to the American Medical Association are Drs. Barrett, Gruber and Huron.

THE SPEAKER: Drs. Barrett, Gruber and Huron. Is that sufficient? Are you satisfied the tellers have rendered their report?

R. S. BREAKEY, M.D. (Ingham): Sworn and testified to by all six tellers.

XIII—g. ALTERNATE DELEGATES TO AMA

THE SPEAKER: The next order of business is the election of Alternate Delegates to the American Medical Association. The present incumbents are Drs. Novy, Denham and Owen. We are to elect three men for these positions, for Alternate Delegates to the American Medical Association.

L. W. HULL, M.D. (Wayne): Mr. Speaker and Gentlemen: I would like to place in nomination the name of Dr. R. L. Novy for Alternate Delegate to the AMA.

E. D. SPALDING, M.D. (Wayne): I second the motion.

THE SPEAKER: R. L. Novy has been nominated. Are there other nominations?

W. B. MITCHELL, M.D. (Kent): I would like to place in nomination the name of R. H. Denham as an Alternate Delegate.

THE SPEAKER: R. H. Denham has been nominated. Are there any other nominations?

W. B. HARM, M.D. (Wayne): I would like to take the opportunity of placing in nomination the name of Dr. C. I. Owen of Detroit, Wayne County.

THE SPEAKER: C. I. Owen has been nominated.

Are there other nominations?

T. P. WICKLIFFE, M.D. (Houghton): I move the nominations be closed.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

THE SPEAKER: It has been moved and seconded that the nominations be closed. Is there any discussion?

R. S. BREAKEY, M.D. (Ingham): My recollection is that in the past—at least it is true in our County Society and I believe it is true in this House—in the choice of Alternate Delegates, in case the regularly elected Delegate cannot attend the Alternates serve in order of the most votes.

THE SPEAKER: Right.

R. S. BREAKEY, M.D. (Ingham): There is a first, second, and third choice of alternates.

THE SPEAKER: Right.

R. S. BREAKEY: There will have to be some sort of vote on this. I am not looking for work either.

THE SPEAKER: The motion before the House is that the nominations be closed. Is there any further discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

Gentlemen, there are three nominees for this position. Will the tellers please pass the ballots? The nominees are Dr. Novy, Dr. Owen and Dr. Denham. There are three vacancies and there are three nominees.

I will read from the new Constitution so we will all understand. Before you vote, gentlemen, will you listen?

"At each annual election, candidates for Delegates to The House of Delegates of The American Medical Association shall be nominated in number equal to or greater than the number to be elected that year. Election shall be by ballot. The required number of high candidates shall be declared elected.

"In case of a tie vote of high candidates, the winner, or winners, shall be decided by drawing lots; supervised by The Speaker of The House of Delegates; provided, however, that any candidate thus tied shall have the right to a decision by ballot if he requests same.

"The number of Alternate Delegates shall equal the number of Delegates. They shall be elected in exactly the same manner after all Delegates have been elected.

"Alternate Delegates shall have relative seniority according to the respective number of votes received by them, and such seniority shall be designated at the time of election."

In other words, gentlemen, you may vote for one, two or three. If everyone in the House votes for three, then the votes will be tied and seniority will be decided by drawing the names from the hat.

The three nominees are Dr. Novy, Dr. Denham and Dr. Owen.

R. S. Breakey, M.D. (Ingham): Since all three men will be elected alternate delegates, if the members of the House would vote for one or two we would establish priority by vote.

The Speaker: I urge the members of the House to vote just as they wish.

R. S. Breakey, M.D. (Ingham): That was only a suggestion. Then you wouldn't have to draw by lot. That is all.

The Speaker: Yes, the members of the House may vote for one, two or three. You have three nominees for three jobs: Dr. Novy, Dr. Denham and Dr. Owen.

(The votes were cast.)

The Speaker: Gentlemen, I think it is rather interesting to hear from some of our ex-Presidents. I am going to call to the microphone now Dr. Claude R. Keyport of Grayling, who was President in 1943-1944, and who has been very active as Delegate to the American Medical Association and very active in Michigan State Medical Society affairs ever since. Dr. Keyport.

Claude R. Keyport, M.D.: Mr. Speaker and Members of the House: I am very happy to be here again. For many years I have been active in Michigan State Medical Society, and I intend to continue my activities so far as possible.

During my term of office as President we were in the war and at that time our meetings were possibly not as many, and we were not showing the same amount of activity that we have since the war.

The House of Delegates and the members of the Michigan State Medical Society have been very kind to me, in the fact that I have been a member of this House for many years, your President-Elect, President, and at the same time a Delegate to the American Medical Association, which position I held for a number of years.

I am happy to release that tonight, and I don't know of anyone I would rather have take my place in the American Medical Association House of Delegates than my good friend, Dr. Huron. Thank you.

XIII—h. PRESIDENT-ELECT

The Speaker: Gentlemen, the next order of business is the election of a President-Elect. Dr. Ledwidge's term will be concluded tomorrow. Dr. Sladek will become President tomorrow, and it is our duty to elect a President-Elect at this time. Are there any nominations for the position of President-Elect of the Michigan Sate Medical Society?

H. H. Riecker, M.D. (Washtenaw): I wish to place in nomination the name of Dr. W. E. Barstow for President-Elect.

The Speaker: The name of Dr. William E. Barstow, Councilor, has been placed in nomination.

M. G. Becker, M.D. (Gratiot-Isabella-Clare): I wish to support the name of Dr. Barstow.

The Speaker: Are there other nominations for the position?

L. C. Harvie, M.D. (Saginaw): I move the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. Barstow.

The Speaker: The motion is that the nominations be closed and the Secretary instructed to cast the ballot for Dr. Barstow, which would be a unanimous ballot.

W. B. Harm, M.D. (Wayne): I second the motion.

The Speaker: The Chair feels it is incumbent on him to ask if there are other nominations, before taking the vote. You have heard the motion which has been seconded by Dr. Harm of Wayne. Is there any discussion? If not, all in favor signify by saying "aye"; opposed, "no." The motion is passed. I declare Dr. Barstow has been elected President-elect of the MSMS.

Will the Credentials Committee please escort the President-Elect to the rostrum.

Gentlemen, when there are more men on the platform than there are in the audience, we will adjourn the meeting.

(The delegates rose and applauded as Dr. Barstow was escorted to the platform.)

The Speaker: Welcome to our growing circle, Dr. Barstow.

J. J. O'Meara, M.D. (Jackson): Mr. Speaker, your President-Elect.

The Speaker: Gentlemen, before we go into that grueling business, let us hear from our President-Elect, Dr. Barstow.

W. E. Barstow: Gentlemen, I have nothing in particular to say, except I certainly appreciate the honor that has been conferred upon me by the House. Thank you.

XIII—i. COUNCILOR—8th DISTRICT

The Speaker: Nominations are now in order for the Councilorship of the Eighth District.

T. B. Treynor, M.D. (Mecosta-Osceola-Lake): I wish to nominate Dr. L. C. Harvie of Saginaw County for Councilor of the Eighth District.

The Speaker: Dr. L. C. Harvie of Saginaw has been nominated. Are there any other nominations?

What is your pleasure, gentlemen?

H. H. Riecker, M.D. (Washtenaw): If I were in that district I would want to have a little consultation with the other members, if any, of that district to decide whom we wanted for Councilor, and we could excuse them from the meeting to talk it over a little bit. If they have done that, I am very glad.

M. G. Becker, M.D. (Grat. Isabella-Clare): We have done that.

H. H. Riecker, M.D. (Washtenaw): We are glad it has been done.

The Speaker: Thank you, Dr. Riecker. Dr. Riecker always sees a lot of things some of us miss.

L. L. Savage, M.D. (Tuscola): I move the nominations be closed.

(The motion was seconded.)

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed and Dr. Harvie has been elected to the position of Councilor of the 8th District.

XIII—j. SPEAKER OF THE HOUSE OF DELEGATES

The next order of business is the election of the Speaker of the House. Nominations are now in order for the position of Speaker of the House.

H. H. Riecker, M.D. (Washtenaw): Mr. Speaker and Members of the House: I wish to place in nomination, as Chairman of the Delegation of Washtenaw County, the name of J. S. DeTar, as Speaker of the House for the coming year.

(R. H. Baker, M.D., the Vice Speaker, took the chair.)

R. A. Springer, M.D. (St. Joseph): Mr. Speaker, may I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. DeTar.

T. Y. Ho, M.D. (Clinton): I second the motion.

The Vice Speaker: It is moved and seconded that the nominations be closed and the Secretary be instructed to cast the unanimous ballot. The present Speaker gives you a chance for other nominations, but I am afraid to request it. All in favor say "aye"; opposed. I declare Dr. DeTar, re-elected as Speaker of The House of Delegates.

(J. S. DeTar, M.D., the Speaker, resumed the chair.)

The Speaker: I want to assure you that this is not as cut and dried as it appears to be.

I hesitated before to think that I should take another year at this job in case I were nominated. I feel that this position should be rotated fairly rapidly, certainly every two or three years. However, you have seen fit to give me this responsibility, and now I should like to give some of this responsibility back to you. This organization is only as good as every member of it. It is difficult at the beginning of the year, it is difficult in June, for a Speaker to choose Reference Committees properly. There undoubtedly are many members of the House of Delegates who would be willing and very glad to serve on Reference Committees. It is difficult to know, without meeting many of you in advance, who has the willingness to work, the desire to work and special interest in certain things.

I would, therefore, like to ask each member of the House of Delegates who is appointed next year—and many of you undoubtedly will be elected next year—I would like to ask you, and I am going to ask you by mail as soon as I can after your election, to write me what are your special interests, whether you would be interested in serving on a Reference Committee, and your suggestions for the more efficient running of the House of Delegates.

Nominations are now open for the position of Vice Speaker.

XIII—k. VICE SPEAKER OF HOUSE OF DELEGATES

T. H. Pauli, M.D. (Oakland): Mr. Speaker, I wish to nominate Robert Baker for the position of Vice Speaker.

The Speaker: The name of Dr. Robert Baker of Oakland County has been placed in nomination. Are there other nominations for the position of Vice Speaker?

R. S. Breakey, M.D. (Ingham): Mr. Speaker, I would like to move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot of this House for Dr. Baker.

The Speaker: Is that motion supported?

T. Y. Ho, M.D. (Clinton): I second the motion.

The Speaker: Is there any discussion? If not, all in favor say "aye"; opposed, "no." The motion is passed.

Dr. Baker, congratulations! Dr. Baker has been a very great help this year, and I am sure that he will be ready to take on additional duties next year.

Dr. Breakey, are you ready with your report?

XIII—g. REPORT ON ELECTION OF ALTERNATE DELEGATES TO AMA

R. S. Breakey, M.D. (Ingham): The order in which the Alternate Delegates were voted was as they are on the board—1, 2, 3.

The Speaker: Dr. Novy received the largest number of votes, Dr. Denham, second, and Dr. Owen was third, and therefore they will appear in that order as Alternates to the House of Delegates of the American Medical Association.

I should like to call on an additional ex-President here. I think the next in line is Dr. Brunk. Dr. Brunk, what happened during your regime?

A. S. Brunk, M.D.: Mr. Speaker, you asked me what happened in my regime. Well, many things happened, of course, as in all the years that the other men have served. I don't know of anything particularly outstanding that happened, not that I can put my finger on at this paricular time that you would be interested in.

I do want to say that I appreciated very much the honor of being invited to the platform and asked to say a few words. I do think, however, that my term of office is just a little bit too recent for me to again impose myself upon you and try to make a speech. I want to thank you for the courtesy.

The Speaker: Thank you, Dr. Brunk.

Dr. Ray S. Morrish of Flint, whose term of office was 1944-1945. Dr. Morrish.

RAY S. MORRISH, M.D.: Mr. Speaker and Members of the House: I wish the Speaker had asked me the question, what happened when I was elected. If I remember rightly, I was pitched into the presidency at about 4 a.m., and through the death of our beloved Dr. Vernor Moore. It meant I didn't have a year's time as President-Elect to think up what some of the policies might be or who my committeemen might be and, if I remember correctly, I had about three weeks' time to work out my committee appointments. Certainly with the good help of The Council and other officers, and during the Annual Meeting with your help, we managed to whittle through some way.

It was a pleasure to serve a year as your President, and perhaps I didn't have the opportunity when I left office, but I will take it now. I certainly thank all for the very kind help and the loyal help which you gave me at that time.

THE SPEAKER: Thank you. Now we will close the meeting, but before we do, I want to say that I feel that the House of Delegates, as the governing body of the Michigan State Medical Society, has a debt of gratitude to certain people.

XV—Thanks of Speaker DeTar to MSMS Officers, House of Delegates, Reference Committee and Personnel

First, I should like to mention our Secretary, Dr. Foster. Dr. Foster has spent so far this year 110 days in the service of the Michigan State Medical Society. He has made twenty speeches away from home, all the way from West Virginia to South Dakota, in addition to carrying on a busy practice.

Dr. Ledwidge has been President of this Society not only in name but in fact. Dr. Otto Beck has spent many hours as Chairman of The Council. Dr. A. S. Brunk has been a very capable Treasurer, doing our business for us.

I would like to mention Mr. William J. Burns and Mr. Hugh W. Brenneman and their staffs. They have been working against almost insurmountable odds in very small, cramped offices in Lansing. We hope they will have a better office soon.

I would hate to close the meeting without special mention of Dr. T. K. Gruber, who did a terriffic amount of work on the Constitution, and I certainly think the names of our Reference Committee Chairmen—Dr. Lightbody, Dr. Bromme, Dr. Donald, Dr. Spalding, Dr. Stucky, Dr. Krieg, Dr. Weston, Dr. O'Meara, and Dr. Smith—should be mentioned. Some of those committees worked until 3 a.m. during the session. They and their committees certainly deserve our special thanks, and also Dr. Baker, who is the Vice Speaker.

I should like to thank the members of the press for their courtesy. We were glad to have you with us—and also Miss Hatton, our stenotypist.

Gentlemen, I should like all elected officers to be in the front row or the front two rows tomorrow night during the Officers' Night ceremony.

I should like to close this meeting with our very best wishes to our President-Elect, E. F. Sladek.

XVI—Adjournment

The meeting is adjourned.

(The Eighty-third Annual Session of the House of Delegates adjourned at eleven-twenty o'clock.)

ASSESSMENT TO PROVIDE EDUCATIONAL PROGRAM

At the recent St. Louis interim session of the American Medical Association, the House of Delegates unanimously voted to assess each member of the Association $25. The fund thus provided will be used for a nationwide plan of education on the progress of American medicine, the importance of the conservation of health and the advantages of the American system in securing a wide distribution of a high quality of medical care. The assessment will come to the members through the state and county societies.

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associated with postoperative inactivity, restricted diets, pregnancy, as well as in simple constipation—Metamucil gently initiates reflex peristalsis and movement of the intestinal contents.

The "smoothage" therapy of Metamucil enables the colon to clear itself without irritating the mucosa.

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POSTGRADUATE CONTINUATION COURSES
Wayne University College of Medicine
December 13, 1948-March 19, 1949

These courses are open to all qualified persons.

Veterans who are not Residents in a Detroit hospital and who have Certificates of Eligibility under the GI Bill, should make arrangements for tuition and books, as provided by the GI Bill, by presenting these Certificates of Eligibility to Mr. Arthur Johnson, Veteran's Administrator at Wayne University, Building N (rear), 465 W. Kirby.

If you do not possess a Certificate of Eligibility, please call Dr. Johnson at Temple 1-1450, Veterans Affairs, before going to his office, and he will inform you what papers it is necessary to bring with you. *This must be completed before you register.*

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, *before December 10.*

Title of Course	*Place*	*Time*	*Fee*
	Anatomy		
Surgical Anatomy *(Limited to 20 Senior Surgical Residents)*	College of Medicine	Tuesday 3–5	$35.00
Advanced Histology	College of Medicine	Monday 2–4	35.00
	Pathology		
Neuropathology	College of Medicine (Limited to 25)	Friday 1–5	50.00
Pathology of Neoplasms	College of Medicine (Limited to 35)	Wednesday 1–5	50.00
Advanced Hematology	College of Medicine (Limited to 5)	Monday 1–5	50.00
Dermatopathology	College of Medicine (Limited to 15)	Tuesday 1–5	50.00
	Radiology		
Beginning Physics in Radiology	St. Mary's Hospital	First meeting, Tuesday December 14, 4:00	15.00
	Physiological Chemistry		
Seminar	College of Medicine	Wednesday 4–5	15.00
Special Topics	College of Medicine	Thursday 4–5	15.00
	Physiology and Pharmacology		
Survey of Pharmacology	College of Medicine	Tuesday 4–5	15.00
Endocrinology	College of Medicine	Mon. & Th. 4–5	25.00
	Dermatology		
Seminar	Receiving Hospital	Wednesday 10–12	15.00
Conference on Venereal Diseases	Social Hygiene Clinic	Thursday 4–5:30	15.00
	Internal Medicine		
Diagnostic Conference	Receiving Hospital (Limited to 10)	Saturday 10–12	15.00
	Wayne County General	Wednesday 4–5	15.00
Gastroenterology	Receiving Hospital (Limited to 10)	Saturday 8–9	15.00
Medical X-Ray Conference	Receiving Hospital (Limited to 10)	Tuesday 11–12	15.00
	Wayne County General	Friday 1–2	15.00
Medical Pathological Conf.	Wayne County General	Thursday 11–12	15.00
Allergy Clinic & Conf.	Receiving Hospital (Limited to 8)	Tuesday 8–11	25.00
	Surgery		
Seminar	College of Medicine (Limited to 20)	Thursday 4–5	15.00

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For patients of intermediate and stocky types of build.

LUMBOSACRAL AILMENTS

An Orthopedic Surgeon* in writing on the treatment of lumbosacral disorders in his book Backache and Sciatic Neuritis states as follows: — "Every patient should be given prolonged conservative treatment before radical measures are considered. Non-operative treatment consists of recumbency in bed, the application of support (adhesive strapping and belts of various types) and physical therapeutic measures. When backache at the lumbosacral junction is uncontrollable by such measures, a fusion operation is recommended."

The Camp Support (illustrated) is a practical, comfortable aid in lumbosacral disorders.

The side lacing adjustment provides a steadying influence upon the pelvic girdle and the lumbosacral articulation. The back is well boned, resting and supporting the lumbar spine.

The garment is easily removed for physical therapeutic treatments.

*Philip Lewin, M. D., F.A.C.S.
Backache and Sciatic Neuritis,
Chapter XXXIX, Page 580
Published 1943 by Lea & Febiger, Philadelphia

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Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

RESEARCH IN SYPHILIS

A new research study in the epidemiology of syphilis has been initiated in the state by the Bureau of Venereal Disease Control, Michigan Department of Health. The co-operation of every practicing physician is invited. The project is concerned primarily with techniques in syphilis case finding, particularly, patient interviewing and contact tracing.

Theoretically, there should be discovered an infected contact for each case of primary or secondary syphilis. Actually this has not been true in Michigan. It has not been unusual in the past to have a case of primary or secondary syphilis name four or five contacts within the usual incubation period. It has happened repeatedly that all of these contacts may be located and examined without a single one being found infected. The most probable sources of error are: (1) inadequate interviewing (including wilful naming of contact that is not actually a contact); (2) locating the wrong person by investigator in cases where there is not complete identifying information; (3) an incomplete medical examination which did not discover the contact's infection.

For the purposes of this study, one venereal investigator has been placed in each of three strategic locations in the state. Following contact interviews in the Michigan Rapid Treatment Center, contact information will be transferred immediately to the State Health Department office and then to an investigator, usually within twenty-four hours. The investigator will immediately attempt to locate the contact and get him to the family physician for an examination. If the contact is located, the results of this examination will usually be known in sufficient time so that if no infection is discovered the patient-informant may be reinterviewed while still at the Rapid Treatment Center.

When the contact has informed the investigator of the name of the physician to whom he will report for examination, the investigator will relay the available contact-information to the physician so that he may have this before taking the history and doing the physical examination. The physician will be asked to report the results of his examination of the contact as soon as possible so that if no infection is discovered further investigation can be made.

This project should result in a relatively large number of referrals to practicing physicians for the specific purpose of determining the presence or absence of syphilitic infections, and for treatment if treatment is indicated.

Much of the success or failure of this research in venereal disease epidemiology will depend upon the active participation and co-operation of practicing physicians in the state. It is believed that results of this study will help improve venereal disease epidemiologic activity and general venereal disease control in Michigan.

TRICHINOSIS SPREAD THROUGH CITY GARBAGE

The feeding of untreated city garbage to hogs increases the danger of trichinosis in hogs and in man.

The sanitary land-fill method of disposal is being recommended. This involves the burial of refuse beneath fill dirt to allow the refuse to settle and decompose. Each day's collection of garbage is sealed off completely on all sides by packed earth. This method cuts down on flies, rats, odors, smoke, open dumps and the health hazards. A tract of land, which can later be used for recreation area, and a caterpillar tractor with bull-chain attachment are the major requirements for such a system.

WHOOPING COUGH INCIDENCE DOWN

Whooping cough is at a new low in the state. Bureau of Disease Control records show that 2,379 cases of the disease have been reported so far this year in comparison with 8,713 at the same time last year. Seven Michigan children have died of whooping cough to date this year, in comparison with an average of 50 deaths at this time in previous years.

RABIES SPREADS NORTHWARD

Rabies in animals by November had spread north of the Muskegon-Bay City line, generally thought to be the northern limit of the 34-county danger area.

A case of rabies in a dog in Oscoda county is believed to have been contracted from a skunk. If a skunk was the source of infection, a reservoir of the disease may exist in wildlife in the area.

Two cases of rabies in dogs were reported from Antrim county.

POLIO LESS COMMON AFTER CHILD IS FIFTEEN

Analysis of the Michigan incidence of poliomyelitis by age groups for the six-year period, 1942 through 1947, indicates that approximately 75 per cent of the cases occurred with age groups under fifteen years and approximately 25 per cent in the age groups, fifteen and over. The only exception was in 1943 when only 65.5 per cent of the cases were in children under fifteen years.

FLUID TETANUS TOXOID AVAILABLE

Fluid tetanus toxoid is now available in 1 c.c. vials, 10 vials to a package.

MOST BREAKFASTS POOR

Nine poor breakfasts are eaten for every good breakfact eaten in the state according to Mrs. Alice Smith, Chief Nutritionist of the Department. Breakfast neglect, she says, is most common among children, particularly

(Continued on Page 1416)

OSCEOLA HOSPITAL

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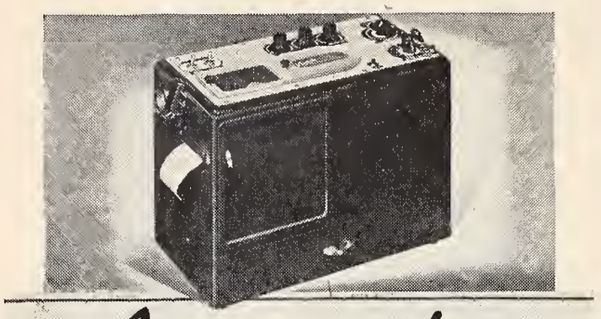
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The Burdick Direct-Recording Electrocardiograph has been tested clinically in several leading medical schools, and has been designed to meet the rigid requirements of the Council on Physical Medicine of the American Medical Association.

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(Continued from Page 1414)

teen-agers, among office, plant and factory workers, and among housewives, especially the mothers of little children. It reveals itself in irritability, fatigue, poor morale, lowered ability to concentrate, lowered efficiency, poor work performance, nervousness, accidents and—even wrinkles, Mrs. Smith contends.

SWEETS CAUSE MOST TOOTH DECAY

Eating sweets is the major cause of tooth decay among Michigan children, according to Dr. Fred Wertheimer, Director of the Bureau of Public Health Dentistry, who is urging Michigan parents to cut down on their children's use of gum (including the bubble variety), candy, pop, chocolate syrup drinks, cookies, cake, pie, jam, jelly and sugar.

He says that the early topical application of sodium fluoride to a child's teeth can reduce tooth decay by nearly half even when the use of sweets is not cut.

USE OF FILM LOAN LIBRARY DOUBLES

Use of the Department's Film Loan Library on health and educational subjects for lay and professional people has more than doubled during the past year. The library was started in 1940. It includes films, film strips, and slides on 159 different topics. They were shown to 355,426 Michigan people in 6,241 gatherings last year.

DELIVERY OF SPECIMENS TO DEPARTMENT

All samples and specimens which are delivered to the Michigan Department of Health for laboratory analysis should be left at the reception desk in the C. C. Young Laboratory building and not in the Administration building.

ADDITIONAL LABORATORY APPROVED

The laboratory of Children's Hospital, 5224 Antoine Street, Detroit, has met requirements permitting performance of enteric bacteriological examinations.

HEART FILM WIDELY SHOWN

The heart disease film "Be Your Age" was shown in one-third of the theaters in the state this spring and summer, according to the Metropolitan Life Insurance Company booking agent for the film.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	October 1948	October 1947
Diphtheria	19	10
Gonorrhea	793	967
Lobar pneumonia	40	60
Measles	313	774
Meningogoccic meningitis	10	10
Pertussis	98	641
Poliomyelitis	161	115
Scarlet fever	259	285
Syphilis	904	1247
Tuberculosis	597	473
Typhoid fever	10	5
Undulant fever	29	25
Smallpox	0	0

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Newly reorganized and modernized for individualized care and treatment of the nervous and mentally ill and alcoholics.

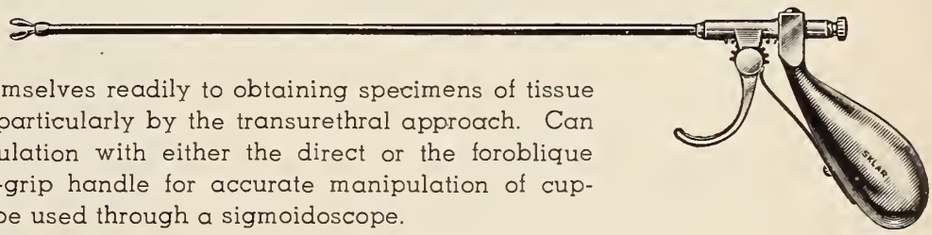
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These fine instruments lend themselves readily to obtaining specimens of tissue from the bladder and urethra, particularly by the transurethral approach. Can be used in endoscopic manipulation with either the direct or the foroblique lens. Rigid shank with pistol-grip handle for accurate manipulation of cup-shaped jaws. Long enough to be used through a sigmoidoscope.

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Braasch bladder specimen forceps with 9½" canula. Stainless steel. Illustrated at right....$50

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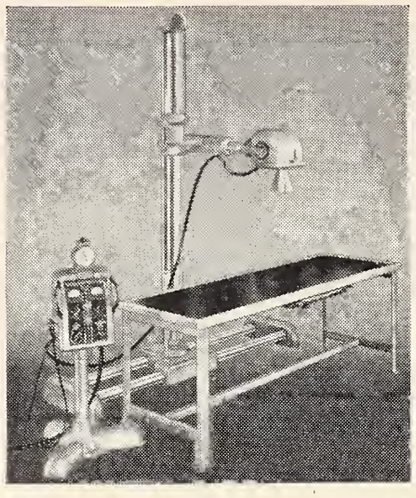
Buie specimen-taking forceps. Same as Braasch model, except with 12¾" canula. Stainless steel $50

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(Continued from Page 1358)

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Complete facilities for training Retarded and Epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

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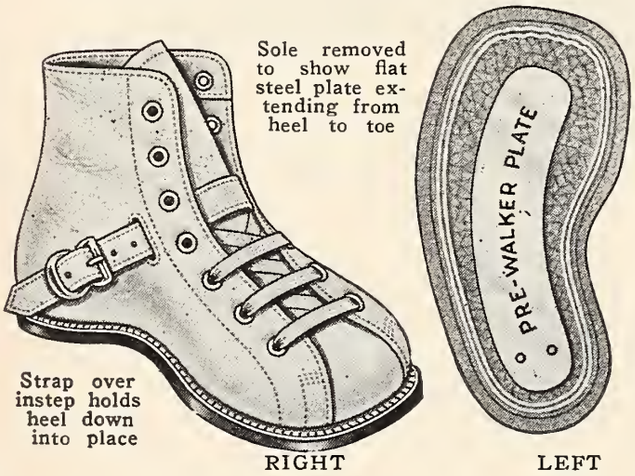
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In Memoriam



ELDWIN R. WITWER, M.D., was born in Huron County, Ontario, Canada, August 23, 1890. He graduated from the Detroit College of Medicine in 1914 and took postgraduate training in Radiology at Cook County Hospital in Chicago. He held the title of Assistant Professor of Radiology at Wayne University and was well known for his organizational work in the Wayne County Medical Society and as a Councilor of the Michigan State Medical Society. Dr. Witwer was past president of the Detroit Roentgen Ray and Radium Society, and for twenty-two years served as its secretary and treasurer. In 1944 he was elevated to the presidency of the Radiological Society of North America. He was a fellow of the American College of Radiology and served the college as chancellor. He was chairman of the Committee on Radiology in Public Health and Industry of the American Medical Association and served on a similar committee in the American Roentgen Ray Society. His medical fraternity was Phi Rho Sigma. Dr. Witwer died on November 2, 1948 at his home in Detroit, Michigan, at the age of fifty-nine years.

CHARLES V. CRANE, M.D., Grand Rapids, Michigan, was born November 28, 1881 in Lake Odessa, Michigan, and graduated from the University of Michigan Medical School in 1904. During World War I, Doctor Crane served as a Lt. Colonel in the Army Medical Corps, and for seventeen years was a member of the Medical Corps. He was a Fellow of the American College of Physicians and Diplomate of the American Board of Internal Medicine in 1937, a member of the Kent County Medical Society, the American Medical Association and the Michigan State Medical Society. He was also a member of the American Diabetic Society, the American Heart Association and the National Gastroenterological Society. Dr. Crane passed on October 10, 1948, in Grand Rapids, Michigan, at the age of sixty-six years.

JAMES F. DARBY, M.D., St. Ignace, Michigan, was born on August 29, 1871 in Dresden, New York, and graduated from the Michigan College of Medicine and Surgery, Detroit, Michigan, in 1895. Dr. Darby was a former president of the Chippewa-Mackinac County Medical Society and a former member of the American Medical Association and the Michigan State Medical Society. He had practiced in St. Ignace, Michigan, for fifty years and had presided at the birth of more than 5,000 infants. Dr. Darby died on September 25, 1948 in St. Ignace, Michigan, at the age of seventy-seven years.

Say you saw it in the Journal of the Michigan State Medical Society

FRANK E. DAWSON, M.D., Detroit, Michigan, was born in Nashville, Tennessee, in 1878 and graduated from the Meharry Medical College, Nashville, Tennessee, in 1917. Dr. Dawson was well known in the negro community of Detroit, and was a member of the Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. He died in Detroit, Michigan, on October 12, 1948 at the age of seventy years.

JOSEPH HANSON, M.D., of Detroit, Michigan, was born April 3, 1876 in Chicago, Illinois. He graduated from the Dearborn Medical College, Chicago, in 1905, and was a member of the Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. Hanson died on September 16, 1948 at the home of his son, in Saginaw, Michigan, at the age of seventy-two years.

WILLIAM B. HOLDSHIP, M.D., of Ubly, Michigan, was born July 26, 1876 in New London, Wisconsin, and graduated from the Saginaw Valley Medical College, Saginaw, Michigan, in 1902. Dr. Holdship was president of the Huron County Medical Society in 1926-27 and in 1934. He served seventeen years on the Village Council, was village president four years and president of the Board of Education the past two years. He was a member of the Huron County Medical Society, the American Medical Association and the Michigan State Medical Society. Dr. Holdship died on September 30, 1948 in Bad Axe, Michigan, at the age of seventy-two years.

CHARLES DAVID HUBER, M.D., Charlotte, Michigan, was born November 8, 1875, in Lodi, Ohio, and graduated from the Wayne University College of Medicine in 1901. Doctor Huber was a former President of the Eaton County Medical Society, a Life Member of the Michigan State Medical Society, and a member of the American Medical Association. He had practiced medicine in Charlotte, Michigan, for more than forty years and died at his home on September 1, 1948, at the age of seventy-two years.

HARLAN D. MacMULLEN, M.D., of Mainstee, Michigan, was born on February 14, 1880 in Osceola County, Michigan, and graduated from the University of Michigan Homeopathic Medical School in 1905. He served as a Captain in the Army Medical Corps during World War I. Dr. MacMullen was Councilor of the 9th District of the Michigan State Medical Society from 1933 to 1937, a Fellow of the American College of Surgeons, a retired member of the Manistee County Medical Society, the American Medical Association and the Michigan State Medical Society. He passed away October 6, 1948 in Manistee, Michigan, at the age of sixty-eight years.

RUSSELL HENRY RENZ, M.D., of Detroit, Michigan, was born in Detroit, Michigan on June 19, 1889. He graduated from the Wayne University College of Medicine in 1914 and was a former member of the



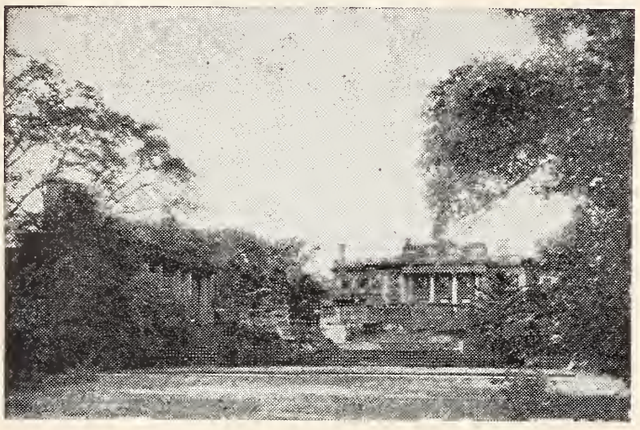
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Wayne County Medical Society, the American Medical Association and the Michigan State Medical Society. Doctor Renz died in Detroit, Michigan, in September, 1947, at the age of fifty-eight years.

ARTHUR JAY ROBERTS, M.D., Jackson, Michigan, was born in Clinton, New York, on March 27, 1859, and graduated from the University of Michigan Medical School in 1885. Doctor Roberts was a former President of the Jackson County Medical Society, an Emeritus member of the Michigan State Medical Society, a member of the "Fifty Year Club," and a member of the American Medical Association. He had practiced at the same location in Jackson for more than fifty years. Doctor Roberts died in Detroit, Michigan, on August 27, 1948, at the age of eighty-nine years.

RAYMOND R. WHITTEN, M.D., of Ionia, Michigan, was born September 29, 1884, and graduated from the Wayne University College of Medicine in 1912. Doctor Whitten was a member of the Ionia-Montcalm County Medical Society, the American Medical Association and the Michigan State Medical Society. He passed away on September 11, 1948, in Blodgett Memorial Hospital, Grand Rapids, Michigan, at the age of sixty-four years.

THE OREGON CASE

(Continued from Page 1326)

members of defendant medical societies should refuse to consult in the diagnosis, care, or treatment of patients of doctors co-operating in medical care plans other than those sponsored or approved by the defendants; or of doctors who are not members of defendant medical societies;

(11) That defendant medical associations be perpetually enjoined from refusing to give approval to any medical care plan on the ground that said plan is controlled or sponsored by a commercial organization; or that said plan provides for medical care of patients having incomes above any given amount; or that said plan would compete with one or more other medical care plans approved or sponsored by the defendants;

(12) That defendant medical societies be required to advise in writing all of their component county medical societies, and to publish a statement in *Northwest Medicine,* that it no longer be the policy of said medical societies to do those things which, as hereinbefore alleged, They have combined and conspired to do, specifically including those things which defendants are enjoined from doing;

(13) That the plaintiff have such other and further relief as the court may deem just and proper;

(14) That the plaintiff recover its costs.

Say you saw it in the Journal of the Michigan State Medical Society

Communications

Michigan State Medical Society
2020 Olds Tower
Lansing 8, Michigan
Gentlemen:

This hospital has been authorized by the Surgeon General, Department of the Army, to employ civilian Medical Officers (General) on a full or part time basis. This authorization has been provided because of the present critical shortage of regular Army Medical Officers.

Because of this critical shortage I am canvassing all Medical Societies and Associations for assistance in obtaining qualified civilian Medical Officers.

Any publicity or assistance which your society may provide in aiding this hospital to obtain either *full* or *part* time civilian Medical Officers will be appreciated.

Thanking you in advance, I remain

Sincerely yours,

(signed) H. D. Offitt,
Brigadier General, USA
Commanding
Percy Jones General Hospital
Battle Creek, Michigan

November 10, 1948

Ann Arbor, Michigan
November 3, 1948

Dear Doctor Sladek:

I was deeply moved by your very gracious and inspiring statement on "Michigan's Pioneering Scientists" in the October issue of The Journal of the Michigan State Medical Society. Such statements as yours go far in stimulating best effort in medical research.

When Doctor Haughey asked me if I would submit some material dealing with the early development of the Kahn test, I did not imagine that The Journal would come out with so fine a commemorative issue. I have already expressed my thanks to Doctor Haughey and the Publication Committee of The Journal. But I feel that I should also like to thank you and, through you as President, the members of the Michigan State Medical Society for this commemorative issue. I have been highly honored by my own colleagues, and it will remain a great incentive to carry on to the best of my ability.

Yours cordially,

(Signed) Reuben L. Kahn

Ann Arbor, Michigan
November 3, 1948

Dear Doctor Haughey:

When your letter came last July requesting that I submit some material to The Journal of the Michigan State Medical Society, I did not imagine that this request would lead to so splendid a commemorative issue. My most sincere thanks to you and to the members of the Pub-

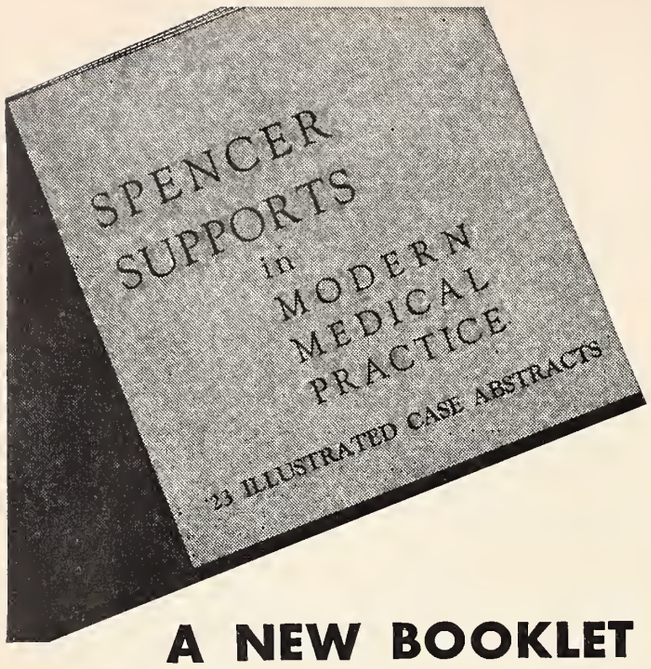


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lication Committee of THE JOURNAL for conceiving and publishing this October issue. I also deeply appreciate the fine compliment paid me by the President of the Michigan State Medical Society, Dr. E. F. Sladek, on his President's Page. It is also a pleasure to express my appreciation of the helpful efforts of your highly efficient Executive Secretary, Mr. Wm. J. Burns, toward the production of this issue of THE JOURNAL.

It is no light matter for one to be so highly honored by his own colleagues not on the completion of his work but at a time when he is still filled with hopes to make significant contributions in his field. Such recognition can only serve as an incentive to strive to be worthy of this honor. I want to assure you that I shall do my very best to continue my studies in the interest of medical science, and that I shall always consider it a privilege to serve the members of the Michigan State Medical Society.

Yours cordially,

(Signed) REUBEN L. KAHN

Hempstead, New York
October 16, 1948

Dear Doctor Haughey:

I received today, a marked copy of THE JOURNAL of the Michigan State Medical Society for September, 1948.

The marked paragraph was in the middle of the second column of page 1034, headed "World Medical Association." There are three mistakes in this paragraph. It should read, "Any member of the Michigan State Medical Society may become a Founder Sustaining Member of the United States Committee of the World Medical Association."

Membership in the World Medical Association itself is limited to national medical associations.

In the fourth line my first name is misspelled.

In the fifth line there is given a combination of my New York and my Hempstead addresses. It should read, "2 East 103rd Street, New York 29, New York." The error in address is particularly important as there is no 103rd Street in Hempstead, and all communications relative to the World Medical Association should be sent to the office of that association in New York.

I would appreciate it if you could run a correction in your next issue.

Sincerely yours,

LOUIS H. BAUER, M.D.
Board of Trustees, AMA

RADIUM DISCOVERED FIFTY YEARS AGO THIS MONTH

Radium was discovered by Marie and Pierre Curie in Paris late in December, 1898.

"On this fiftieth anniversary of its discovery the value of radium for the treatment of cancer and other diseases is well established and its limitations are well known," Dr. Christie says in his editorial, adding:

"We pause to pay tribute to the discoverers and pioneers, but in proportion as we have their faith and vision we will fix our eyes upon the possibilities of progress which are opening up before us in the field of radioactivity. Much has been accomplished already in exploration of the field of the artificially produced radioactive isotopes."—American College of Radiology, December, 1946.

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"Michigan is one state that is setting the pace in prepayment of health care."—GEN. PAUL R. HAWLEY, M.D.

* * *

R. L. Novy, M.D., Detroit, has been elected as a trustee of Michigan Hospital Service to fill the unexpired term of Wilfrid Haughey, M.D., resigned.

* * *

England's socialized medicine experiment reminds one of that old quotation, "The people love the early stages. A honeymoon is always pleasant."

* * *

L. Fernald Foster, M.D., spoke to the Kalamazoo Academy of Medicine on November 16 at its regular monthly meeting. His subject was "Good Public Relations Pay."

* * *

Of the 3,399 registrants at the 1948 MSMS Annual Session in Detroit, 1,598 came from Wayne County (1,371 were from Detroit, alone).

In addition, 186 came from outside Michigan, including 80 from Canada!

1949 Institute.—A good Doctor of Medicine is always under instruction. Plan to attend the 1949 Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit, March 23-24-25—a continuation course with forty-three good instructors.

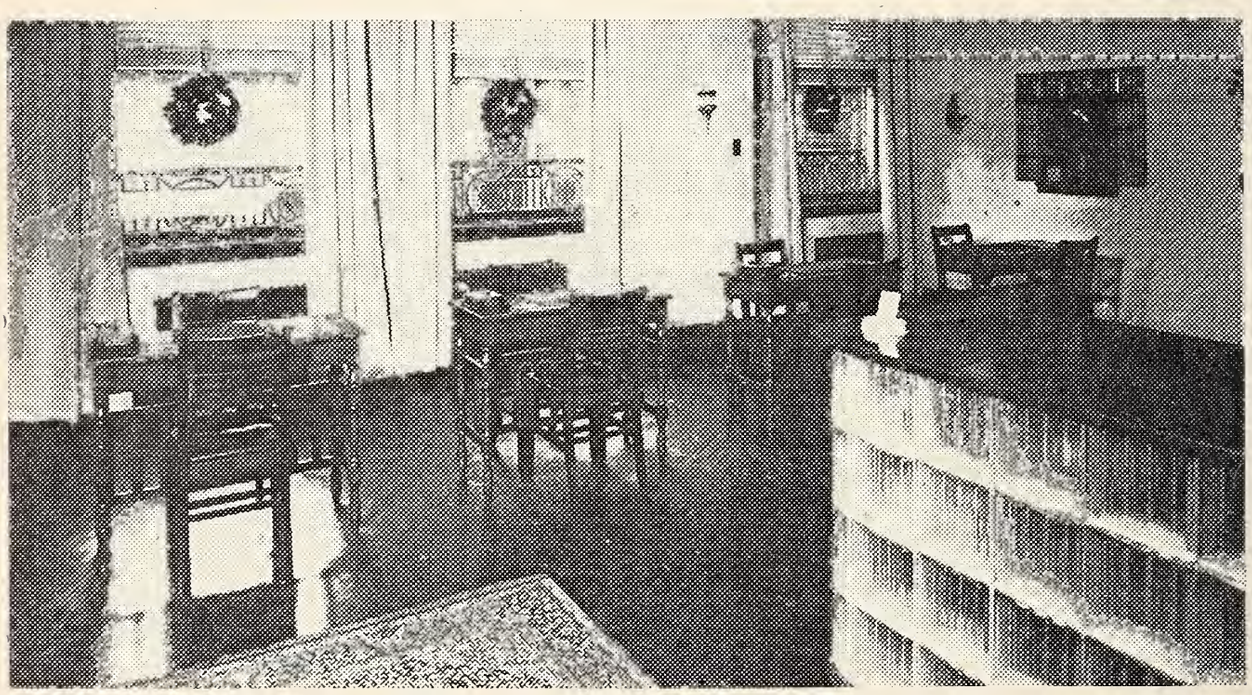
David J. Sandweiss, M.D., Marcus H. Sugarman, M.D. and Bruce C. Lockwood, M.D., all of Detroit, are authors of an original article, "Enterogastrone and Duodenal Ulcer," which appeared in *JAMA* of October 23, 1948.

* * *

"Doctors' Wills and Estates" was the interesting subject of an address before the Ingham County Medical Society presented by Cyril Heilmann, a member of the legal profession of Michigan.

* * *

The Michigan State Board of Registration in Medicine stated, as of November 8, 1948, that it reinstated the medical licensure of William A. Kopprasch, M.D., and Carl W. Wagar, M.D.



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R. S. Breakey, M.D., Lansing, delivered his presidential address on "Problems of Enuresis," to the North Central Section of the American Urological Association in Des Moines, Iowa, on October 28.

* * *

LeMoyne Snyder, M.D., J. D., and Wm. J. Burns, LL.B., Lansing, have been appointed members of the Medical Jurisprudence Committee of the State Bar of Michigan for the year 1948-49 by President Frank H. Boos of Detroit.

* * *

Grover C. Penberthy, M.D. and Clifford D. Benson, M.D., Detroit, are authors of an original article "The Complications of Meckel's Diverticulum in Infants and Children," which was published in *Surgical Clinics of North America,* October, 1948.

* * *

R. Wallace Teed, M.D. of Ann Arbor, Michigan, read a paper at the annual meeting of the Academy of Ophthalmology and Otolaryngology, October 10 to 15, in Chicago, on "Contribution of War Experience to the Etiology of Otitis Media."

* * *

Infant Mortality in Michigan.—In 1946 there were 4,552 deaths of infants under one year of age as against 4,035 in 1945, but due to the greatly increased number of births the rate decreased from 35.8 per thousand live births to 32.7, a decrease of 3.1 per thousand.

* * *

E. I. Carr, M.D., Lansing, was appointed by President E. F. Sladek, M.D., to represent the Michigan State Medical Society at a conference arranged by the American Cancer Society, Michigan region, to plan for extension of home nursing service. The meeting was held in Lansing on November 12.

* * *

Diabetes.—There is reported to be 2,500,000 known diabetics in the United States. The American Diabetic Association has announced a campaign to find the estimated 1,000,000 hidden cases. A shorter blood sugar test is being experimented with, and an improved insulin.

* * *

Detroit Dermatological Society.—At the annual meeting the following officers were elected by the Detroit Dermatological Society: Charles E. Reyner, M.D., Detroit, president; Frank Stiles, M.D., Lansing, president-elect; Herbert H. Holman, M.D., 2010 David Broderick Tower, Detroit, secretary-treasurer.

* * *

H. W. Brenneman, MSMS Public Relations Counsel, addressed a joint meeting of the Public Relations Committees of the Calhoun County Medical Society and of the Michigan State Pharmaceutical Association in Marshall on October 26. The meeting stressed closer contact between these two professional groups and better understanding of mutual problems.

* * *

Michigan Medical Service.—The annual meeting of the Directors of Michigan Medical Service, held in Detroit, October 13, resulted in the re-election of the same

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officers: Robert L. Novy, M.D., president; Wilfrid Haughey, M.D., vice president; P. L. Ledwidge, M.D., secretary, and Frank McAllister, treasurer. Mr. Milton Grinnell resigned, and the vacancy was filled by the election of E. C. Baumgarten, M.D., of Detroit.

* * *

The Michigan Society of Anesthesiologists held its monthly meeting, December 1, in Lansing.

The program was a symposium on Intravenous Procaine. Dr. W. G. Mackersie discussed the "Use of Intravenous Procaine in Thoracic Surgery"; Dr. Ivan B. Taylor, "The Use of Intravenous Procaine in General Surgery"; and Dr. N. M. Bittrich, "The Therapeutic Uses of Intravenous Procaine."

* * *

L. Fernald Foster, M.D., Bay City, addressed the Michigan Society for Crippled Children and Adults at its twenty-fifth annual meeting in Flint on October 29. His subject was "Our Michigan Rheumatic Fever Diagnostic Center Program—New Developments."

Carleton Dean, M.D., Lansing, presented the Michigan Crippled Children Commission's "amputee and brace reconditioning and retraining program" on October 30, at the MSCC Annual Session.

* * *

Veterans Administration will soon receive formal notification by the American Legion of actions taken at its recent Miami convention which pertained to medical and hospitalization activities . . . among them were rejection of proposals to add chiropractors to VA staffs, opposition to any "federal socialized medicine program," endorsement of provision of living quarters for hospital staff doctors.—Washington Report on the Medical Sciences, November 1, 1948.

* * *

C. E. Umphrey, M.D., Detroit, represented the Michigan State Medical Society in a one-day institute entitled "Community Resources for Adult Medical Care in Michigan" sponsored by the Michigan Welfare League and held in Detroit, December 6, as part of the MWL Annual Conference. The panel and round-table discussions included representatives of the medical, hospital, and health professions and directors of welfare and vocational rehabilitation.

* * *

Vocational Rehabilitation. The State Office of Vocational Rehabilitation requests that, in forwarding statements for medical care of its clients, the examining physician fill in his usual charge for the service rendered, according to the Uniform Fee Schedule for Governmental Agencies. However, where this is not done, no amount will be entered by the Vocational Rehabilitation office without prior consultation with the physician concerned.

Vocational rehabilitation has set a fee of $8 on rehabilitation examinations. This is an improvement over the fee for similar examinations paid by insurance companies.

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Fifth CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE

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For a copy of the Vocational Rehabilitation examination blank, write N. Bernita Block, M.D., Medical Consultant, State Board of Control for Vocational Education, Bauch Bldg., Lansing 4, Michigan.

* * *

Robert M. Eaton, M.D., Grand Rapids, was top winner in the contest for medical papers published in recognized state and national medical journals prior to January 1, 1948—awarded by the Foster Foundation Committee on Medical Prizes. Dr. Eaton's "Pulmonary Edema" won him a $250 prize.

William H. Deemboer, M.D., and Henry P. Kooistra, M.D., took second place ($100), Aymer M. Hill, M.D., and Jerome E. Webber, M.D., placed third, ($100) and John T. Hodgen, M.D., and Charles H. Frantz, M.D., fourth ($50).

* * *

Workingmen's Worries.—The November number of *Fortune Magazine* contains an article giving the results of a questionnaire of the UAW-CIO showing the things which cause the working men worry. The average age of the CIO worker is 42.7 years and the average number of dependents is 3.1, which is one whole dependent less than the average for the state. 28 per cent of them worry about what they would do to care for their families in case of illness and 15 per cent of them worry about how they would take care of the medical and health expenses of their dependents. This is a very interesting survey and worth reading.



Frederick A. Coller, M.D., Ann Arbor, was chosen as president-elect of the American College of Surgeons in Los Angeles at its 1948 meeting the week of October 18.

Congratulations, Dr. Coller, and full success in your new position.

* * *

M.H.S.: Five of the thirteen Sisters of Mercy hospitals in Michigan which withdrew from participation in the Blue Cross program in 1946 have again become Blue Cross hospitals, it was announced on November 10 by William S. McNary, executive vice president of Michigan Hospital Service, the Blue Cross Plan.

The hospitals are: Mercy Hospital, Muskegon; Mercy Hospital, Cadillac; Leila Y. Post Montgomery Hospital, Battle Creek; Mercy Hospital, Jackson; and St. Lawrence Hospital, Lansing.

* * *

According to John Perkins, state controller, the state has three ways to balance the budget since Proposal No. 2 was defeated and sales tax diversion continues: (1) Levy a state income tax, a state property tax or various "nuisance" taxes; (2) Recapture such present grants in aid to local governments as the intangibles tax, racing

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Surgical Technique, Surgical Anatomy and Clinical Surgery, four weeks, starting February 7, March 7.
Surgical Anatomy and Clinical Surgery, two weeks, starting February 21, March 21.
Surgery of Colon and Rectum, one week, starting March 7, April 11.
Surgical Pathology every two weeks.

GYNECOLOGY—Intensive Course, two weeks, starting February 21, March 21.
Vaginal Approach to Pelvic Surgery, one week, starting February 14.

OBSTETRICS—Intensive Course, two weeks, starting March 7.

MEDICINE—Intensive Course, two weeks, starting April 4.
Personal Course in Gastroscopy, two weeks, starting March 7.

PEDIATRICS—Intensive Course, four weeks, starting April 4.

DERMATOLOGY—Formal Course, two weeks, starting April 18.
Clinical Course every two weeks.

CYSTOSCOPY—Ten-Day Practical Course every two weeks.

ROENTGENOLOGY—Lecture and Diagnostic Course, two weeks, starting the first Monday of every month. Clinical Course starting third Monday of every month.

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revenues, etc.; and (3) Make local units responsible for such present state services as welfare, care of tuberculous patients, old age assistance and aid to dependent children.—*Michigan Survey, November,* 1948.

* * *

90th Division Forming Association.—All former members of the 90th Infantry Division are invited to affiliate with the Michigan Chapter of the National Association now being formed.

The association is being formed to perpetuate the friendships formed while serving our country in time of war in the United States, England, France, Belgium, Luxembourg and Germany.

Communications should be addressed to Frank A. Schmidt, Jr., 65 E. Fairmont Avenue, Pontiac, Michigan.

* * *

The Governor of Michigan, Mr. Kim Sigler, called a conference at the Olds Hotel, Lansing, November 11, 12, and 13, on "Children and Youth in Michigan." The purpose was to study the present staff of public and private services to the children, evaluation in the light of today's need, and plan for the future so that Michigan may offer the greatest public encouragement, inspiration, and help to its future citizens. There were five general sessions, group luncheons, and twenty-two section conferences, also a Governor's Dinner on Friday evening, November 12.

* * *

Michigan Deaths, 1947.—The Federal Security Agency reports deaths in Michigan for 1946, 54,899; for 1947, 56,847. A total of 1,445,370 deaths were registered in the United States during 1947. This represents an increase of 49,753 deaths over the number recorded for 1946. "The crude death rate for 1947 was 10.1 deaths per thousand estimated population. *This is the second lowest rate ever recorded for the United States. The lowest was 10.0 in 1946."* This from the FSA report, and THIS WAS UNDER A SYSTEM OF VOLUNTARY PRIVATE MEDICAL PRACTICE!

* * *

Dr. Reuben L. Kahn, Ann Arbor, was honor guest at a testimonial dinner at the Statler Hotel, Boston, arranged by the Conference of State and Provincial Public Health Laboratory Directors, on the occasion of the Annual Dinner of the Conference, November 7.

A formal presentation was made to Dr. Kahn of the first copy of the October, 1948, JOURNAL, MICHIGAN STATE MEDICAL SOCIETY, to come off the press, which commemorated the 25th Anniversary of the Kahn reaction. G. Don Cummings, M.D., Lansing, Director of Laboratories of the State of Michigan, made the presentation address.

* * *

The Family Doctor in magazine articles.—

1. The *Saturday Evening Post* of October 9 contained an article on a Texas general practitioner.

2. *Life* Magazine on September 20 carried an interesting story concerning a Colorado general practitioner, as well as an editorial entitled "General Practice vs. Specialization."

3. *Woman's Home Companion* recently purchased full-page advertisements in metropolitan newspapers to

Say you saw it in the Journal of the Michigan State Medical Society

carry its message entitled "Give Young Doctors a Break" to the public. Although the story was badly garbled, it did point the finger at some impractices in certain hospital setups in certain parts of the U. S.

* * *

The Michigan State Pharmaceutical Association invites the attention of the medical profession to a portion of the agreement which it has with the Veterans Administration for pharmaceutical service to VA patients: No doctor of medicine may prescribe medicine for a veteran under the VA program unless he is specifically authorized in each instance (for each patient, per month) to make out such prescription. These prescriptions are checked carefully by the Pharmaceutical Association and any doctor who writes prescriptions on patients for whom he has no authorization from VA will be billed for the prescription.

* * *

President-elect W. E. Barstow, M.D., of St. Louis, comments that he has many times noticed the danger of driving at night when long freight trains are moving. He has cared for many patients who were injured by driving into moving freight trains which they could not see. He suggests that the Interstate Commerce Commission, which is probably the only authority that can control this condition, require that every freight car carry three reflectors on each side which will flash back the lights of the driver's automobile when approaching a moving freight train at night, thus giving notice that there is something ahead. As the trains are now equipped, the long line of freight cars gives no warning in the dark, and on the country roads there are no lights at the crossings.

* * *

The convention dollar means a great deal to the host city. For example, Cleveland recently surveyed the conventionneer's dollar and found the following disbursement:

Hotel accommodations (including rooms, food, and incidentals)—37.18 cents
Restaurants—15.7 cents
Beverages—9.85 cents
Retail stores—12.99 cents
Local transportation—4.18 cents
Theaters—1.44 cents
Sight seeing—0.29 cents
Amusements—8.62 cents
Gas, oil, car service—1.87 cents
Miscellaneous—7.88 cents

* * *

New Intramural Postgraduate Course in Cancer. This important course begins Tuesday, January 25, and continues daily through Friday, January 28, 1949; it will deal primarily with the four most common cancers, namely, those of the skin, breast, uterus, and rectum. The course will be offered to qualified practitioners residing in Michigan. The program will be given in the University Hospital, Ann Arbor, Michigan, and will consist of four general lectures, one on each day of the course, and also four daily sessions on pathology. The entire group of physicians will attend those periods. The re-



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mainder of the day will be given over to clinical sessions, the group being divided into four sections. Each section will rotate through four clinical sessions on successive days. For applications, your members may write to H. H. Cummings, M. D., Chairman, 1313 E. Ann St., Ann Arbor, Michigan.

* * *

Study of Michigan Basic Science Act and of Michigan Medical Practice Act.—A joint committee representative of the Michigan State Medical Society, the Michigan Board of Examiners in Basic Sciences, and the Michigan State Board of Registration in Medicine, has been appointed to study possible changes in the Michigan Basic Science Act of 1937 and in the Michigan Medical Practice Act of 1899.

The personnel of this committee, appointed by the president of the Michigan State Medical Society, is as follows: P. L. Ledwidge, M.D., Detroit, Chairman, and E. F. Sladek, M.D., Traverse City, representing the Michigan State Medical Society; O. E. Madison, Ph.D., Detroit, and Donald A. Kerr, D.D.S., Ann Arbor, representing the Board of Examiners in Basic Sciences; and C. B. Gardner, M.D., Lansing, and L. J. Gariepy, M.D., Detroit, representing the Michigan State Board of Registration in Medicine. This joint committee was appointed as the result of a meeting of representatives of the three groups held in Lansing on October 11.

* * *

Almost three out of every four of the twenty-four and twenty-five-year-olds called up for pre-induction physical examinations are unfit for military service, according to a survey of the nation's ten largest cities.

Selective service officials reported that the rejection rate varies from 87.5 per cent in New York City to 37 per cent in Los Angeles. The average is 72 per cent, as compared with 35.8 per cent during World War II.

Heart ailments and psychoneurotic disorders are the principal causes of rejection.

Selective service officials said that because veterans are exempted from the new draft, most of those being examined now were 4-Fs during the war or held essential jobs. Selective Service Director Lewis B. Hershey said the rejection rate among the twenty-four and twenty-five-year-olds is just about what he expected, perhaps a shade better.

* * *

If the rate of 72 per cent continues, the Army will not be able to fill its three-month quota of 45,000 men from the ranks of the twenty-four and twenty-five-year-olds, as it had planned. It has asked for 10,000 this month, 15,000 in December, and 20,000 in January.—B. C. Enquirer News, Nov. 3, 1948.

* * *

Longer Life for Doctors.—Early in 1940 the class of 1900 of the College of Physicians and Surgeons, Columbia University, New York, held its annual dinner. As the toll of members who had died in the last year was intoned, the surviving doctors blinked with shocked surprise. A group of the naughty-naughts, then in their late 60s, began to investigate the alarmingly high death rate. The next year a Committee on Longevity was announced, with Dr. Charles E. North, bacteriologist, as chairman.

Say you saw it in the Journal of the Michigan State Medical Society

The committee's findings were equally shocking. A gallstone authority did not know he had gallstones. A hernia specialist had a hernia. Other members had poor sight and nose and throat ailments. Only three had normal weight; 35 were too fat and 23 too thin.

On advice of the committee, all members of the class agreed to take frequent examinations and treatments for any ailments discovered. Classmates examined each other without charge. Last week the committee made an official report on the eight-year plan. In that time the group, averaging 75 years, had an annual death rate of five members. This compares favorably with a national rate of 6.7 persons in 100 over 65, as listed in a government survey.—Extract from *Newsweek,* October 25, 1948.

* * *



Bill Porter — Olympic Hurdles Record Breaker. —Horace Wray Porter, M.D., of Jackson, longtime and efficient Secretary of the Jackson County Medical Society, has good reason to be proud of his son Bill Porter, Northwestern University's great hurdler. To quote the *Northwestern Wildcat News:*

"Young Bill Porter climaxed his brilliant track career when he won the Olympic 110 meter hurdles championship at London in the record-breaking time of 13.9 seconds."

Dr. Porter's lanky son (6 feet 6 inches), in addition to his triumph at London, has also equalled the American indoor record for the 60 and 70 yard high as well as for the 70 yard low hurdles.

Congratulations, Dr. Porter, on your son's remarkable accomplishments!

* * *

The AMA Secretary's Letter of October 25, 1948, presented the following story about "Lucky Junior": Michigan Society produces new movie. Several persons from AMA headquarters recently saw a preview showing of "Lucky Junior," a new 10-minute movie produced under sponsorship of the Michigan State Medical Society. It is now being booked for showing by more than 400 theaters in Michigan. An estimated audience of more than 1,000,000 persons will see this motion picture, which is interesting and very well done. Subsequently, the state society plans to develop 16 mm. prints for showing to community groups.

"Lucky Junior" was chosen as the title for the educational film because it is designed to show the safeguards available to the child of today as compared with those of yesteryear.

The picture deals with the thoughts of a doctor who has just delivered his 2,000th baby. He recalls how he delivered the child's father twenty-five years ago, and



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thinks how much better a chance this baby has to grow up to healthy manhood than his father had.

As the doctor recounts to himself the advantages which today's child enjoys, the picture illustrates modern protective measures—the up-to-date hospital, protection by immunization against such deadly diseases as whooping cough, diphtheria, and tetanus, and services such as the disease control programs.

EXTRACTS FROM 1948 MSMS HOUSE OF DELEGATES PROCEEDINGS

(Continued from Page 1316)

any segment of medicine cannot suddenly be changed by any single formula or law.

"WHEREAS, According to the principles of medical ethics it is unprofessional to accept rebates on prescriptions, appliances or perequisites from attendants who aid in the care of patients, we believe it will be the consensus of the House of Delegates that the membership of the Michigan State Medical Society and of the medical profession in general is as honest and as much to be trusted in all of its responsibilities as any other group of citizens, be it therefore

"RESOLVED, That it is the consensus of this House of Delegates that the ophthalmologist's responsibility for glasses as a therapeutic agent is a medical problem not to be separated from the eye examination,

"That we urge that the ophthalmologists accept the responsibility involved in the proper merchandising of glasses to their patients."

4. *Effort to increase the number of students graduated from medical schools.* The 1948 House of Delegates adopted the following resolution:

"RESOLVED that the Michigan State Medical Society, through its officers, support any reasonable means to increase the number of students graduated from medical schools in this state, and that the Delegates to the AMA take similar action at the next meeting of the American Medical Association House of Delegates."

An MSMS committee has been appointed to meet with the Deans of the two Medical Schools in Michigan, with the Governor, and with the Ways and Means Committee of the House and the Finance and Appropriations Committee of the Senate, State Legislature, to investigate the possibility of increasing the number of students graduated from medical schools in this State. The committee is composed of President E. F. Sladek, M.D., Traverse City, Chairman; Speaker J. S. DeTar, M.D., Milan, and Secretary L. Fernald Foster, M.D., Bay City.

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SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

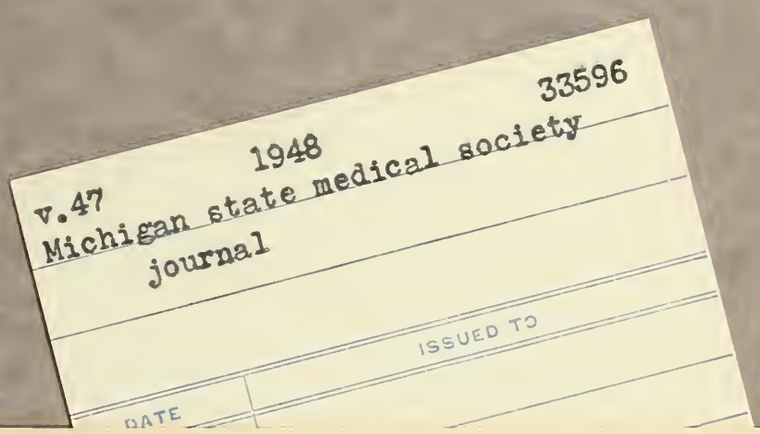
*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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